Authorization for PRESCRIPTION Medications to be taken during school hours

PARENT SIGNATURE REQUIRED

School _____

Child's Name _____ ____ _____
Last First Sex Date of Birth

_____
Physician's Name Address Telephone Number

- I give permission for the exchange of verbal and written communication between the physician and the school nurse regarding my child's medication regimen.
- I request that my child be assisted in taking the medicine(s) described below at the school by authorized persons or permitted to medicate herself/himself as also authorized by me and my physician *(see below)*.

☐ INIT **I understand that I, or another designated adult, will need to pick up this medication from the school nurse at the end of this school year. In the event this medication is not picked up, I understand that the remaining medication will be destroyed/ disposed of by the District/ school nurse.**

_____ _____ _____ _____
DATE **PARENT/GUARDIAN SIGNATURE** Date Witness

PHYSICIAN SIGNATURE REQUIRED - MEDICATION WILL NOT BE ADMINISTERED WITHOUT PROPER PHYSICIAN AUTHORIZATION

DIAGNOSIS for which medication is given: _____

NAME of MEDICINE: _____

FORM: _____ DOSE: _____

State TIME for DAILY Medication: _____

If medication is to be given WHEN NEEDED, describe indications: _____

How soon can it be repeated? _____

Is child authorized to medicate herself/himself? _____

List significant side effects: _____

Length of time this treatment is recommended: _____

Other Information: _____

DATE: _____ **PHYSICIAN SIGNATURE:** _____