BRIGHTON AREA SCHOOLS

Medication Prescriber/Parent Authorization Form

"Medication" shall include prescription, over-the-counter medication and homeopathic per BAS **Policy #5330** *Use of Medications*

Student Name_____ DOB_____ School_____ Grade_____ School Year_____

To be completed by physician/licensed prescriber:

Medication Name	Dose	Time to be given	Form/Route	Side Effects
1.				
2.				

List minimal frequency between doses if PRN/ as needed: _____

If PRN, list symptoms/condition under which medication is to be given: _____

SPECIAL INSTRUCTIONS: _____

Inhaler Use: This student may carry their inhaler and is capable of self administration: Yes ◯ No ◯

Start Date_____ Stop Date_____

_____ _____ _____

Physician's Signature Date Printed Name

Physician Phone#_____ Fax#_____ Address_____

TO BE COMPLETED BY PARENT/GUARDIAN

I request and give permission for (name of child)_____ to receive the above medication(s)/treatment at chool according to standard school district policy and for the physician/ staff and school district staff to share information needed to assist my child with medication needs. **The school requires parent/guardian to bring medication in the original container.**

_____ _____ _____

Parent Signature Date Phone Number