

HUSD Prescription Medication Prescriber / Parent Authorization Form

Student Name: _____ Birthdate: _____ Teacher: _____ Grade: _____ School year 2026-2027

To be completed by Physician / Licensed Prescriber:

	Medication Name	Dose	Time to be given	Reason for Medication	If PRN - list symptoms/ conditions for medications	Side effects/Adverse reactions
1						
2						

Circle Route of Administration ~

- Oral (Pill / Capsule / Chewable / Liquid)
- Inhaled (Inhaler / Nebulizer)
- Topical (Ointment / Eye drop / Ear drop)
- Injectable (Subcutaneous / IM)

List minimal frequency between doses (especially if P.R.N. medication): _____

Special Instructions: _____

Start date if not beginning of the school year: _____ Stop date if not end of school: _____

Physician's Signature
Date
Physician's Printed Name

Physician's Phone #: _____ Fax: _____ Address: _____

To be completed by Parent / Guardian:

I request and give permission for (Name of student) _____ to receive the above medication(s) or treatments at school according to standard school district policy and for the Licensed Prescriber's staff and school district to share information needed to assist my child with medication needs. (Schools require parents / guardians to bring medication in its original container).

Parent / guardian signature
Date