Natomas Unified School District
Connecting students to their future

Health Services

MEDICATION AUTHORIZATION - PROVIDER FORM

Student Name _____ Date of Birth _____

A separate provider form is needed for each medication.

HEALTH CARE PROVIDER STATEMENT (To be completed by health care provider)

The student named above is under my care for the following medical diagnosis: _____

_____

Student has been prescribed the following medication: _____

Medication	Dose/Amount	Route/Method	Time/Frequency	Duration
☐ Scheduled ☐ PRN		☐ PO ☐ IM ☐ Inhalation ☐ Other:_____		

For PRN medication: Symptoms that would necessitate administration: _____

_____

Precautions or side effects: _____

Student was instructed in the use, safety, and need for medication ☐ Yes ☐ No

Student is competent to carry and self-administer medication ☐ Yes ☐ No

Student may carry medication but needs assistance with administration ☐ Yes ☐ No

If student cannot self-administer medication and requires assistance, a trained unlicensed assistive person/trained health care aide may administer the prescribed medication. ☐ Yes ☐ No

Other recommendations: _____

_____

(To be completed by health care provider)

☐ As the prescribing physician, I authorize the school to administer the above listed medication in accordance with the instructions noted.

_____ _____

Physician's Signature Phone/FAX

_____ _____

Physician's Printed Name Date

_____

Address (Street, City, State, Zip)