



Medication Authorization Form

Student Name: _____ Date of Birth: _____

School: _____ Phone: _____ Fax: _____

*****Prescription medication must be in the container in which it was purchased with a pharmacy label attached; over-the-counter medications must be in a new unopened bottle. No medication (including over-the-counter medication and supplements) will be given at school without a current prescription from a licensed physician. The first dose of any new medication is required to be given at home under parent/guardian supervision.*****

PARENT/GUARDIAN SECTION

I request that my child, _____, be assisted in taking the below prescribed medication at school by the nurse or principal's designee. I will comply with the school's policies and procedures. I will notify the school if there are changes in my child's health status, changes in medication or change in health care provider. I authorize exchange of information between my child's Physician, District Nurse, or site administrator with regard to this medication request.

Parent/Guardian Signature

Date

Phone Number

PHYSICIAN SECTION: (to be completed by health care provider) One Medication per Form

Name of medication: _____

Dosage: _____

Time(s) to be given at school: _____

Route to be given: _____ Controlled substance? Yes No

Reason for medication/Diagnosis: _____

Possible side effects & Emergency Response: _____

It is necessary for this medication to be taken during the school day at the time(s) indicated above.

Physician Signature: _____ Date: _____

Physician Name: _____

Clinic Address: _____

Clinic Phone Number: _____ Fax: _____

*****Form must be renewed every school year or whenever the prescription changes.*****