

**PHYSICIAN AUTHORIZATION
FOR MEDICATION TO BE
TAKEN DURING
SCHOOL HOURS
School Year 2026-27**

School _____ Fax # _____

The following section is to be completed by the PARENT:

Child's Name (Last) _____ (First) _____

Sex _____ Birth Date _____ Physician's Name _____

Physician's Phone # _____ Fax # _____

I am requesting that, during school hours, the school nurse or designated person administer this prescription medication ordered by authorized persons below. I give permission to the school nurse to destroy any medication remaining at the end of the school year if I do not pick it up.

Date: _____ Parent Signature _____

Home Phone _____ Emergency Phone _____

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PHYSICIAN:

Reason for Medication _____

Name of Medication _____

Form of Medication _____ Tablet/Capsule _____ Liquid _____ Inhaler _____ Injection _____

Other (explain) _____

Instructions (Schedule and dose to be given at school) _____

Start (Date form received) _____ Other Date _____

Stop _____ July 30, 2027 Other Date _____

_____ For episodic/emergency events only

Restrictions and/or important side effects: None expected _____

Yes, (Describe) _____

Special Storage Requirements _____ None _____ Refrigerate _____ Other (explain) _____

Please indicate if you have provided additional information _____ on reverse side _____ attachment

Date _____ PHYSICIAN'S SIGNATURE _____

Address _____ Phone _____