Authorization for Medication

STUDENT NAME:_____ DATE:_____
ADDRESS:_____DATE OF BIRTH_____
_____ __SCHOOL_____

Please have physician complete and sign this form for any prescriptions medications or over the counter medications that you want your child to be given at school. This form must be signed by a Physician.

Name of Drug _____
Dosage:_____
Time & Route_____
For Period_____to _____
Reason for Medication_____
Relevant Side Effects_____
_____
_____

Name of Drug:_____
Dosage:_____
Time and Route:_____
For Period_____to_____
Reason for Medication_____
Relevant Side Effects_____
_____
_____

Name of Drug _____
Dosage:_____
Time & Route_____
For Period_____to _____
Reason for Medication_____
Relevant Side Effects_____
_____
_____

Name of Drug:_____
Dosage:_____
Time and Route:_____
For Period_____to_____
Reason for Medication_____
Relevant Side Effects_____
_____
_____

Additional Comments:_____

If no time limit is specified, this order will expire in one year.
Physician's Name: (please print)_____

Physician's Signature _____Date:_____

National Provider Identification number (Medicaid Required): NPI#_____

Address:_____Phone:_____

I hereby request that school personnel provide my child, _____with this medication to be administered as prescribed above and will not hold the Board of Education, or its personnel responsible for complications related to this administration.

Parent's Signature:_____Date:_____

A Dosage change must be accompanied by a Physician's Prescription