

PARENT'S AND PRESCRIBER'S AUTHORIZATION FORM
ADMINISTRATION OF PRESCRIPTION MEDICATION IN SCHOOL

Authorization for Administration of Medication

A. To be completed by the parent or guardian:

I request that my child _____ grade _____ receive the medication as prescribed below by our licensed health care prescriber. The medication is _____ to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication.

B. To be completed by the licensed health care prescriber:

I request that my patient, as listed below, receive the following medication:

Name of Student: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication: _____

Prescribed Dosage, Frequency and Route of Administration:

Time to Be Taken During School Hours: _____

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____

Other Recommendations: _____

Name of Licensed Prescriber and Title (please print): _____

Prescriber's

Signature: _____ Date: _____

Address: _____ Phone: _____