

## Medication Prescriber/Parent Authorization Form

Student Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_ School Year: \_\_\_\_\_

**To be completed by physician/licensed prescriber:**

	Medication Name	Dose	Time to be given	Form/Route*	Side Effects	Adverse Reactions
1						
2						

\*Routes ~ oral (pill/capsule/chewable, liquid) ~ inhaled (inhaler, nebulizer) ~ topical skin application ~ topical (eye drop, ointment) ~ topical ear drop ~ injection ~ other (list)

List minimal frequency between doses (especially if p.r.n.): \_\_\_\_\_

If p.r.n., list symptoms/conditions under which medication is to be given: \_\_\_\_\_

Reason for medication (optional): Medication #1 \_\_\_\_\_ Medication #2 \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Start date if not beginning of the school year: \_\_\_\_\_ Stop date if not end of the school year: \_\_\_\_\_

\_\_\_\_\_  
Physician's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Printed name

\_\_\_\_\_  
Physician's Phone #:

\_\_\_\_\_  
Fax #:

\_\_\_\_\_  
Address:

**To be completed by parent/guardian:**

I request and give permission for (name of child) \_\_\_\_\_ to receive the above medication(s)/treatment at school according to standard school district policy and for the physician('s)/staff and school district staff to share information needed to assist my child with medication needs. (Schools require parent/guardian to bring medication in its original container).

\_\_\_\_\_  
Parent/guardian signature

\_\_\_\_\_  
Date