



AUTHORIZATION FOR PERScription MEDICATION AT SCHOOL
(MUST BE SIGNED BY PARENT AND PHYSICIAN)

PLEASE PRINT

SCHOOL YEAR: _____

STUDENT'S NAME: _____

BIRTH DATE: _____

LEGAL GUARDIAN: _____

DAYTIME PHONE: _____

NAME OF MEDICATION: _____

REASON FOR GIVING MEDICATION AT SCHOOL (PLEASE BE SPECIFIC):

AMOUNT OF MEDICATION TO BE GIVEN: _____

TIME OF DAY MEDICATION IS TO BE GIVEN AT SCHOOL: _____

DATE TO START MEDICATION: _____

DATE TO STOP MEDICATION: _____

EXPIRATION DATE OF MEDICATION: _____

POSSIBLE SIDE EFFECTS: _____

PHYSICIAN SIGNATURE: _____

DATE: _____

OFFICE PHONE #: _____

PARENTS PLEASE READ CAREFULLY:

I understand that all medication will be provided by me in the original container, clearly labeled with my child's name. I will notify the school if the medication is discontinued or the dosage has been changed. Permission is granted to the principal and/or school nurse to share this information with individuals who have responsibility for my child. The first dose will be given at home so that I can monitor adverse reactions. I give the school nurse my permission to contact the above named physician's office to request medical information concerning my child. I am responsible for replacing medication before the expiration date.

LEGAL GUARDIAN'S SIGNATURE: _____

DATE: _____