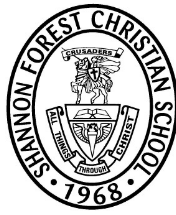

AUTHORIZATION FOR PERSCRIPTION MEDICATION AT SCHOOL

(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: ______________