Authorization for Administration of Medication in School

To be completed by the parent/guardian:

I request that my child _____ in grade ____ receive the medication as prescribed below by our health care provider. 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.

X Signature of parent/guardian _____

Telephone: Home _____ Work _____ Date _____

To be completed by your family health care provider:

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

Name of Student _____ DOB _____

Diagnosis _____

Medication _____

Dose, Frequency, and Route of Admission _____

Time to be taken during school hours _____

Duration of Treatment _____

Possible side effects _____

_____ _____
Date Physician Name (please print)

_____ X _____
Address Physician Signature

_____
Phone

To be completed by the school nurse:

I agree to administer the medication as requested by the parent/guardian and in accordance with the above prescription from the physician.

_____ _____
Date School Nurse Signature