AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Parents/Guardians asking school staff to give medications to their child must provide (written) permission from themselves and the health care provider every school year.

Student Name: _____

Date of Birth: _____ Grade: _____ School Year: _____

MEDICATION MUST BE SUPPLIED IN THE ORIGINIAL PRESCRIPTION BOTTLE

START DATE: _____ STOP DATE: _____

MEDICAL CONDITION	MEDICATION	DOSE	TIME	ROUTE *(eg. Oral)*	POSSIBLE SIDE EFFECTS
1					
2					
3					
4					

PARENT/GUARDIAN AUTHORIZATION

I request that the above medication(s) be given during school hours as ordered by my child's physician/licensed prescriber. I also request the medication be given on field trips as prescribed.

I will notify the school of any change (ie dosage change or stoppage) in medication(s).

I give permission for the school nurse to communicate as needed with school staff about my child's health condition(s) and the action of the medication(s).

I give permission for the school nurse to consult with my child's physician/licensed prescriber concerning any questions regarding the above listed medication(s) or medical condition(s) being treated by the medication(s).

_____ _____ _____

Parent/Guardian signature Relationship to student Date

Physician/Licensed Prescriber Information:

Clinic address: _____ DATE: _____

Phone: _____ FAX: _____

Signature: _____ PRINT NAME:_____