AUTHORIZATION FOR MEDICATION: Prescription or Over-the-Counter Medication

Student's Name: ________________________Date of Birth: ________________Grade: ______________

School: ________________________________Phone #: _____________________Fax#: _______________

Allergies: ____

Diagnosis: ____

MEDICATION	DOSAGE & ROUTE	FREQUENCY	SPECIFIC TIMES	SPECIAL INSTRUCTIONS/ SIDE EFFECTS

List any emergency precautions / health emergencies that should be anticipated for this student; e.g. allergy triggers, diabetic reactions, etc.) : ____

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Physician's Name (Printed) **Physician's Signature**

Physician's Telephone & Fax Numbers

Physician's Office Address **Date Completed**

PARENTAL PERMISSION FOR MEDICATION

(TO BE COMPLETED BY THE STUDENT'S PARENT / GUARDIAN)

Student's Name: ________________________Date of Birth: ______________Grade: ________________

I grant the principal or his / her designee the permission to assist or perform the administration of each medication to or for my child during the school day, including when he/she is away from school property for official school events. If my child has been authorized by his/her physician to self-administer their medication(s), I grant permission for my child to self-administer their medication at school and when they are away from school property for official school events. In the event that my child is unable to self-administer their medication, I give permission for the principal/designee to perform the administration of the prescribed medication. I also grant permission for the principal or his/her designee to contact my child's physician should they have any questions or concerns regarding this medication order.

NOTE:

- **Medications must be supplied in the original container.** Ask the pharmacist to divide the medication into two completely labeled containers, providing one for home and one for school.
- School personnel may administer only medications authorized by a physician.
- It is your responsibility to notify the school when there is a change in medication regimen.

Parent / Guardian Name (Printed) Signature of Parent / Guardian

Date Signed Home Phone Number

Work/Cell Phone Number (Include Ext. if any)

REVISED 8/16