Physician Authorization for Medication

Name of Student: _____ Date of Birth: _____

Address: _____ Grade: _____

City/Zip: _____

Name of Licensed Prescriber: _____ Title: _____

Business Telephone Number: _____ Emergency Number: _____

I have determined that it is necessary for this medication to be administered during school hours.

Medication to be administered: _____

Route: _____ Dosage: _____ Frequency/time(s) of administration: _____

Other specific directions or information regarding this medication/administration:

Optional information:
1. Special side effects, contraindications, or possible adverse reactions to be observed:

2. Other medication being taken by this student:

3. The date of the next scheduled visit or when advised to return to prescriber:

4. Consent for self-administration, provided the school nurse determines it is safe and appropriate.

Yes: _____ No: _____

_____
Signature of Licensed Prescriber

_____
Date

Parent Authorization for Medication Administration

Name of Student: _____ Date of Birth: _____

Parent/Guardian name (print): _____

Phone Numbers: Home: _____ Work: _____ Emergency: _____

Other person(s) to be notified in case of a medication emergency:

Name: _____ Phone Number: _____

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality):

Any special directions, signs to observe, side effects:

My son/daughter has the following food or drug allergies:

Date to discontinue medication:_____

Follow up visit to prescriber: _____

_____ I am requesting the school nurse or designated school personnel to administer the medication prescribed

by:_____ to _____.
(Licensed prescriber) (*Student)*

_____ I am requesting that the school nurse or designated person administer this over-the-counter (OTC), non-prescription drug according to the manufacturer's directions. _____

_____ I give permission for my son/daughter to self-administer medication, if the school nurse determines it is safe and appropriate.

_____ I request the above student receive this medication according to the prescription or parental request for OTC drug, and any special instructions. I understand the information is confidential according to the Family Rights and Privacy Act (FERPA), and school personnel, needing to know, have access to this information. I agree to coordinate and work with school personnel and the prescriber if questions arise. I understand I may cancel this request at any time, and/or retrieve the medication from the school at any time. I understand the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Parent/Guardian Signature: _____ Date: _____

Relationship to Student: _____

Address: _____

_____