PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Authorization for Administration of Medication

A. To be completed by the parent or guardian:
I request that my child _____grade_____, receive the medication as prescribed below by our licensed health care prescriber. 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.
********I give permission for the nurse to share pertinent information regarding my child's illness with necessary staff as indicated by my initials_____.**

Signature of Parent or Guardian: _____

Address: _____

Telephone: Home_____Work:_____Date:_____

B. To be completed by the licensed health care prescriber:
I request that my patient, as listed below, receive the following medication:

Name of Student: _____Date:_____

Diagnosis:

_____

Name of Medication: _____

Prescribed Dosage, Frequency and Route of Administration:

_____

Time to be Taken During School Hours: _____

Duration of Treatment:

_____

Possible Side Effects and Adverse Reactions (if any) _____

_____

Other Recommendations: _____

Name of Licensed Prescriber and Title (please print) _____

Prescriber's
Signature: _____Date:_____
Address: _____Phone:_____