# PARENTS AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. To be completed by parent or guardian

I request that my child, _____, grade ____ receive the medication as prescribed by our licensed 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.

Grades 6-12: May self-administer and carry on self _____

Signature (Parent/Guardian) _____
Address: _____
Telephone: Home _____ Work _____ Cell _____
Date _____

B. To be complete by the licensed health care provider:

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

Name: _____Birth Date: _____
Diagnosis: _____
Name of Medication: _____
Prescribed Dosage, Frequency and Route of Administration: _____
_____
_____
_____
Time Medication is to be Taken During School Hours _____
Duration of Treatment _____
Possible Side Effects and Adverse Reactions (if any) _____
_____
_____

Can this Student self-medicate and carry on self? Yes _____ No _____

Name of Licensed Provider and Title ( Please Print) _____
_____
Date _____