PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

a. To be completed by the parent or guardian:

I request that my child _____, DOB_____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*****.

PLEASE CHECK ONE:

☐ I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips, to my **self directed child.** ***(Please have your physician fill out Self-Medication Release Form on reverse side of this form.)***

☐ I understand that administration of oral, topical or inhalant medications to my **non self-directed child** and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician or parent.

Signature (Parent or Guardian):_____Date:_____

Telephone: Home_____ Work _____ Cell_____

b. To be completed by physician:

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

Name of Student_____ DOB_____

Diagnosis:_____

_____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any):_____

_____

Physician's Name/Address:_____ Telephone:_____

Physician's Signature:_____ Date: _____

*****Medication must be in original pharmacy labeled container with specific orders and name of medication.
*****Medication and refills must be brought to school by parent/guardian or responsible adult.

(OVER)