



Prescription Medication Authorization Form
One sheet per medication

TO BE COMPLETED
BY A
PHYSICIAN

Student Name: _____ DOB: _____ Grade: _____ Reason for Medication: _____

Name of Medication: _____ Dose: _____ Route: _____ Time: _____ Effective dates: _____

Checking here indicates that the medication is an Epi-pen or inhaler that the student can carry and self administer: _____

Possible Adverse effects: _____

Possible drug interactions: _____

Additional Instructions: _____ Student Allergies: _____

Physician/Prescriber Signature: _____ Date: _____ Physician phone #: _____

Printed Name of Physician: _____

This request must be signed by a parent or guardian and the health care provider to authorize giving the medication during school hours .

Prescription medicine must be delivered to the nurse in a container properly labeled by a pharmacist with identifying information, e.g., name of the child, medication dispensed, dosage prescribed, and the time it is given. Pharmacists will provide a second labeled container if requested.

I release the school and its personnel of any liability related to the administration of the above listed medication. I give permission to the school personnel to communicate directly with the prescribing physician and for the physician to discuss my child's health and medical care with the school's health care staff.

Parent or Guardian Signature _____

Date _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug																															
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Apr																															
May																															
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Codes: X - Weekend
H - Holiday
A - Absent

FT - Field Trip
N - None Available

School Nurse/
Delegate Signature: _____

Initials: _____