# AUTHORIZATION FOR MEDICATION

The following section is to be completed by the **PARENT:**

School_____

Child's Name _____ DOB _____ Gender _____

Physician's Name _____ Phone # _____

Physician's Address _____

I request that my child be assisted in taking the medication(s) described below at school by authorized persons as authorized by my health care practitioner and me (see below). I understand that I must transport medication to and from the school.

Parent/Guardian Signature _____ Date _____

Home Phone # _____ Emergency Phone # _____

The following section is to be completed by the **HEALTH CARE PRACTITIONER:**
**(Note: School personnel should not administer any medication that could be taken at home.)**

Diagnosis for which medication is given _____

Name of medication(s) _____

Form _____ Dose _____

If it is medically necessary to administer at school, at what time_____

If medication(s) is to be given "when needed", describe indications _____
_____

How soon can it be repeated _____

List significant side effects _____

Length of time this treatment is recommended _____

Is this a rescue medication? _____
Is the student authorized to self-carry and administer the medication? _____

**OTHER INFORMATION**

_____

Signature of Health Care
Practitioner_____Date_____

Updated 3/8/13