AUTHORIZATION FOR PRESCRIPTION MEDICATION OR TREATMENT

Part A: To be completed by the physician

Name of Student: ______________________________ DOB: ____________

Street ____________________________________ PO Box ____________

City ____________________ State ____________ Zip ______

School: ____________________________

I have prescribed the following:

Medication/Treatment ______________________________________

Dosage ______________________________________

Time to be given at school ______________________________________

If **Asthma inhaler** may student carry on person: ____________

If **Epi-pen** may student carry on person: ____________

Is student trained to self administer medication? ______ Yes ______ No

Begin Date: ______________ End Date: ____________________

Side effects, Instructions, or precautions:

____

____

____

____________________________ ____________________
Physician's Signature Date

____
Telephone

____________________________ ____________________
Printed/Typed Name Fax

Part B: To be completed by the Parent /Guardian

I request authorized school personnel to follow the medical instructions requested in PART A. I agree to see that the medication is delivered to the school: to notify the school if there is a change in physicians: to notify the school if the medication, dosage, or procedure is changed or discontinued. I give my consent to the physician, school nurse, or their designees to send and/or receive information related to my child's health as they deem appropriate for the duration of this order as noted above.

*****Please note medication must be in pharmacy labeled bottle.**

DATE ________ Signature of parent/Guardian ______________________________

****Note: Please pick up all medications at the end of the school year. They will be destroyed if they are not picked up

Revised 09/14/11