

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 _____