School Medication Authorization Form

To be completed by the student's parent/guardian. A new form must be completed each school year. Please complete one form per medication. Medications must be brought to the school office in the original container.

Student's Name: _____ Birthdate: _____

Address: _____

Home Phone: _____ Cell Phone: _____

To be completed by the student's physician.

Physician's Name (printed): _____

Office Address: _____

Office Phone: _____

Medication Name: _____

Purpose of Medication: _____

Dosage: _____ Frequency: _____

Time medication is to be administered at school or under what circumstances: _____

_____

Prescription Date: _____ Order Date: _____

Discontinuation Date: _____

Expected Side Effects (if any): _____

Other medications student is receiving: _____

Physician's Signature: _____ Date: _____

Parents must also complete the next page