

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

STUDENT INFORMATION

Student's Name _____ Date of Birth _____

School _____ Grade _____ Teacher _____ School Year _____

List any known drug allergies/reactions _____ Height (inches) _____ Weight (lbs) _____

PRESCRIBER AUTHORIZATION

Name of Medication _____ Reason for Taking _____

Dosage _____ Route _____ Frequency/Time(s) to be given _____

Begin Medication _____ Stop Medication _____
Date Date

Special Instructions:

Does medication require refrigeration? Yes No

Is the medication a controlled substance? Yes No

Potential Side Effects/Contradictions/Adverse Reactions _____

Treatment Order in the event of an adverse reaction: _____

(Attach additional sheet or use the back of this form if necessary)

Signature of Prescriber (please print) _____ Date _____ Phone _____ Fax _____

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to delegate to unlicensed school personnel the task of assisting my child in taking the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up about the medication.

Medication must be registered with the principal, his/her designee, or the school nurse. It must be in the original, unopened, sealed container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

Signature of Parent _____ Date _____ Phone _____ Cell _____