Physician's Authorization for

Prescription Medication

or

Over-The-Counter Medication

****PLEASE MAKE A COPY OF THIS FORM IF THE PHYSICIAN WRITES FOR MORE THAN ONE MEDICATION FOR APPLICANT****

Name of Applicant ____
(Last) (First) (MI)

- I understand that I must supply the school with the equipment/supplies needed to administer the medication.
- I understand that all medications must be labeled with the name of the medication, name of student, name of physician, date, and directions for administration. Prescription medication must be labeled by a registered pharmacist.
- I hereby authorize the medication described below to be administered as directed by my child's physician.
- I understand that the physician will be called if a question arises about my child's medication
- I understand I will be notified when a prescription needs to be refilled and that I must get medication refilled and either bring or send the medication to the Medical Office in a timely manner to avoid a lapse is medication administration.
- 911 will be called immediately in an emergency.

____
(Signature of Parent/Guardian) (Date)

COMPLETED BY PHYSICIAN

NOTE: Only One Medication Allowed Per Form

1. Name of Medication ____
2. Reason for Medication ____
3. Type of Device ____
4. Specific direction for use ____
   - Is the applicant capable of self-administering the medication by device? ____YES ____NO
   - Should applicant carry medication and device with him/her? ____YES ____NO
5. Dosage and Time of Medication ____

Physician's Printed Name & Signature ____

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