MEDICATION AUTHORIZATION FORM

Student's Name _____ Age ____ Grade____ Teacher _____

Physician/Dentist _____ Phone Number _____

Pharmacy _____

Name of Medication _____

Diagnosis (What is the medication for?) _____

_____

_____

Amount to be given _____ Time to be given _____

Is this medication to be given "as needed" ◯ **OR at a specific time** ◯ **(please check one)**

Starting date _____ Ending date _____

Amount sent to school _____

I request that the prescribed drugs or medication be dispensed according to these written instructions. I request that a qualified staff person give this medication. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.

Parent signature _____ Date _____

Home Phone _____ Work Phone _____ Cell Phone _____

MEDICATION WILL NOT BE GIVEN IF IT HAS EXPIRED OR IF IT HAS AN IMPROPER LABEL. PLEASE CHECK THE CONTAINER BEFORE SENDING IT TO SCHOOL.

SUGGESTION: WHEN YOU PICK UP YOUR PRESCRIPTION ASK YOUR PHARMACIST FOR A BOTTLE LABELED FOR SCHOOL USE.