Medication Authorization Form

Student Name: _____ **Birth Date:** _____ **School Year:** _____

Allergies: _____

Please list all medications that will be given at school including prescription and over the counter. A physician/NP/PA and legal guardian must sign this form before any medication can be administered. This form must be renewed each school year or sooner with any changes to medication order (dose, time, etc).

****Physician to fill out this form****

	Medication Name (in original container)	Student's Dose	Time(s) to be given during school	*Form/Route	Can student self-possess/self-administer?	PRN indications
1						
2						
3						
4						
5						

**Routes-oral (pill, capsule, chewable, liquid). Inhaled (inhaler, nebulizer). Topical (cream, lotion). Injection (needle), G or J Tube*

List any adverse reactions that should be reported to parent: _____

Physician name (print): _____ **Phone:** _____ **Fax:** _____

Physician Signature: _____ **Date:** _____

Address: _____

I authorize appropriately trained school personnel to administer medication and to exchange medication/medical information with my child's physician as deemed necessary. I understand that it is my responsibility to inform appropriate school staff of any changes in my child's health and to provide a new PHYSICIAN's order for each change in my child's medications. I also understand that medications must be brought in by a parent/guardian in the current original container with the accurate instructions on the prescription label.

Parent/Guardian Signature: _____ **Date:** _____