MEDICATION AUTHORIZATION

PHYSICIAN: COMPLETE ALL ITEMS IN BOLD

Student's Name:____Date of Birth:_____/____/_____

School:____________________________________Telephone:____________________FAX: __________________

The above student has a medical condition that requires medication to be administered at school.

Medication:_____________________**Dosage**:___________**Route**:__________**Frequency**: ___________________

Time(s) medication is to be given:_________________**Dates to be given from**:_____/____/____**to**/_____/____/_______

(Medication request will be in effect until the beginning of the next school year unless otherwise specified.)

Type of medication: (circle) Tablet Capsule Liquid Inhalation Ointment Injection Other

Significant Information (side effects, adverse & omission reactions):

____

____

This medication will be furnished by parent or guardian in a container properly labeled by a pharmacist with identifying information (i.e. name of child, medication dispensed, dosage prescribed and the time to be given).

Medication:_____________________**Dosage**:___________**Route**:__________**Frequency**: ___________________

Time(s) medication is to be given:_________________**Dates to be given from**:_____/____/____**to**/_____/____/_______

(Medication request will be in effect until the beginning of the next school year unless otherwise specified.)

Type of medication: (circle) Tablet Capsule Liquid Inhalation Ointment Injection Other

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Medication:_____________________**Dosage**:___________**Route**:__________**Frequency**: ___________________

Time(s) medication is to be given:_________________**Dates to be given from**:_____/____/____**to**/_____/____/_______

(Medication request will be in effect until the beginning of the next school year unless otherwise specified.)

Type of medication: (circle) Tablet Capsule Liquid Inhalation Ointment Injection Other

Significant Information (side effects, adverse & omission reactions):

____

____

This medication will be furnished by parent or guardian in a container properly labeled by a pharmacist with identifying information (i.e. name of child, medication dispensed, dosage prescribed and the time to be given).

Physician's Signature:____________________________Telephone:____________________Date:_____/___/_____

OFFICE USE ONLY

Principal's Signature:_ _Date:____

MEDICATION RETURNED ON:_____________(DATE)______________________(SIGNATURE)