



Name: _____
Unit #: _____
School Year: _____

Authorization for Administration of Medication:

A. To be completed by the parent or guardian:

I request that my child, _____, receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication to my child.

Signature (Parent or Guardian): _____

Address: _____

Telephone: Home _____ Work _____ Cell #: _____

B. To be completed by the licensed health care prescriber:

I request that my patient, as listed below, receive the following medication:

Name of Student: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication: _____

Prescribed Dosage, Frequency and Route of Administration: _____

Time to be Taken During School Hours: _____

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____

Other Recommendations: _____

Name of Licensed Prescriber and Title (please print): _____

Prescriber's Signature: _____ Date: _____

Address: _____ Phone: _____