PHYSICIAN AUTHORIZATION AND PARENTAL REQUEST FOR ALL MEDICATIONS

_________________________ _________________ _______________
Student's Name Grade/Homeroom Date of Birth

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER

Diagnosis/Reason for medication: ____

Name of medication: ____

Medication Form: _____tablet/capsule _____liquid _____inhaler _____injection

Special Storage Requirements: ______refrigerate ______none ____other___________

Start Date: _________________ Stop Date: _____end of school year _____ other

_____ for episodic/emergency events only

Instructions/Schedule and dosage given:____

Restrictions/Side Effects: ____

Adverse reactions that should be reported to the physician: ____

If prescribing an EPIPEN or RESCUE INHALER, is student capable and responsible for self-administering this medication _____yes _____supervised _____unsupervised _____ no
May student carry the EPIPEN or RESCUE INHALER _____yes ____no

Procedure to follow if medication does not produce expected relief: ______________________________

____

Date: ___________________ Signature:____
Physician's (name printed): ____
Address: ____
Phone Number: ____________________ Emergency Phone Number: _____________________________

TO BE COMPLETED BY PARENT/GUARDIAN
I give permission for _________________ to receive the above medication at school or field trips according to school policy. It is understood that the school and its personnel are absolved from any responsibility, which may be associated with the administration of such medication. I understand that the medication must be brought to school in its original container or in the container to which it was dispensed by the pharmacist.
Date: ___________________ Signature of Parent/Guardian: ______________________________________
Address: ______________________________ Phone: ____