PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. <u>MUST BE COMPLETED BY THE PARENT OR GUARDIAN</u>:

I request that my child, _____ Grade: _____

Receive Drug: _____ Dose:_____ Frequency: _____

Reason/symptoms: _____

The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication.

Signature (Parent or Guardian): _____ Date: _____

Telephone: Cell/Home: _____ Work: _____

B. <u>MUST BE COMPLETED BY THE LICENSED HEALTHCARE PRESCRIBER</u>:

Authorization for Administration of Prescription and/or Non-Prescription Medication

I request that my patient, as listed below, received 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: _____

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

Other Recommendations: _____

Permission to self-carry and self-administer: YES _____ NO _____

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

Prescriber's Signature: _____ Date: _____

Address: _____ Phone: _____

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