

MEDICATION REQUEST AND AUTHORIZATION FORM FOR PRESCRIPTION AND OVER-THE-COUNTER MEDICATION

Edwardsburg Public Schools

Student Name: _____ Date: _____

School: _____ Grade: _____ DOB: _____

Diagnosis/Reason for Medication: _____

Prescription Medication	Dosage	Time	Special Instruction
Over-the-Counter Medication	Dosage	Time	Special Instruction

Physician Comments (please list any probable side effects or restrictions)

For Over-the-Counter Medication Please Check Option 1 or 2 Below:

1. _____ self-administer such medication(s) in the presence of an authorized staff member
2. _____ keep the medication(s) in his/her possession and self-administer the medication(s) as needed

***Physician Signature:** _____ **Date:** _____
(Required for prescription and over-the-counter medication to be given at school/extra-curricular activities)

Physician's Address and Phone: _____

I have received and understand the Parent Guidelines for Medications at School. I request that my child be given the medications above according to the instructions listed. I agree to notify the school in writing if medication is discontinued and provide a new authorization form if the medication, dosage, schedule, or procedure is changed.

Parent Signature: _____ Date: _____