Prescription Medication Authorization

If medication can be given at home or after school hours, please do so. However, if medication must be given during school hours, this form must be completed.

Student's Name: ___________________________________

Teacher: ____

TO BE COMPLETED BY PARENT

I wish my child to be given, at school, the medication prescribed by

Dr. _______________________ *on this date* ___________.

____

Parent's Signature

TO BE COMPLETED BY PHYSICIAN

Name: ____

Medication: ____________________________________

Frequency & Dosage: ______________________________

Side Effects To Be Observed, If Any: _____________________

Approx. Duration of Treatment: ________________________

Condition Being Treated: ____________________________

__________________________ __________

Signature of Physician *Date*