



Physician's Authorization for
Prescription Medication
or
Over-The-Counter Medication

****PLEASE MAKE A COPY OF THIS FORM IF THE PHYSICIAN WRITES FOR MORE THAN ONE MEDICATION FOR APPLICANT****

Name of Applicant _____
(Last) (First) (MI)

- I understand that I must supply the school with the equipment/supplies needed to administer the medication.
- I understand that all medications must be labeled with the name of the medication, name of student, name of physician, date, and directions for administration. Prescription medication must be labeled by a registered pharmacist.
- I hereby authorize the medication described below to be administered as directed by my child's physician.
- I understand that the physician will be called if a question arises about my child's medication
- I understand I will be notified when a prescription needs to be refilled and that I must get medication refilled and either bring or send the medication to the Medical Office in a timely manner.
- 911 will be called immediately in an emergency.

(Signature of Parent/Guardian)

(Date)

COMPLETION BY PHYSICIAN

NOTE: Only One Medication Allowed Per Form

1. Name of Medication _____
 2. Reason for Medication _____
 3. Type of Device _____
 4. Specific direction for use _____
 - Is the applicant capable of self-administering the medication by device? ___ YES ___ NO
 - Should applicant carry medication and device with him/her? ___ YES ___ NO
 5. Dosage and Time of Medication _____
- Physician's Printed Name & Signature _____