Authorization For Medication

Name of Student: _____ DOB: _____ Grade: _____

School: _____

Phone Number: _____ Fax Number: _____ Date: _____

* *

MEDICATION TREATMENT PLAN TO BE COMPLETED BY PHYSICIAN

Diagnosis: _____

_____

Medication, Dosage, Specific Times & Direction for Administration (Please write each medication, dosage, frequency and time separately): _____

_____

_____

NOTE: Medication must be supplied in the original prescription container. Ask pharmacist to divide the medication into two completely labeled containers, providing one for home and one for school.

Side Effects/Special Instructions: _____

_____

_____

NOTE TO PHYSICIANS: Please complete the treatment plan on the back of this form for students who require any special health procedures during school hours (i.e.: inhalers, nebulizer treatments, catheterization, suctioning, tube feedings, glucose testing, etc.).

Printed Name or Stamp of Physician: _____

Physician's Signature: _____

Physician's Phone Number: _____

Physician's Fax Number: _____

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PARENTAL PERMISSION TO BE COMPLETED BY PARENT/GUARDIAN

I grant the principal or his/her designee the permission to assist in the administration of each prescribed medication/procedure to be provided during the school day, including when _____
(Name of Student)
is away from school property on official school business.

Signature of Parent: _____ Date: _____

Home Phone Number: _____

Work Phone Number: _____

Treatment for Students Needing Health Procedures During School Hours

Treatment Plan: _____

Special Procedures (List special procedures in which students have been trained (i.e.: insulin administration, use of Epi-Pen, nebulizer, testing glucose levels, etc.):_____

Please list any limitation that should be considered (i.e.: physical education, outdoor activities, etc.): _____

Please state the emergency precautions that should be considered (i.e.: allergy triggers, diabetic reactions, etc.) _____

Physician's Signature: _____ Date: _____