PHYSICIAN AUTHORIZATION AND PARENTAL REQUEST FOR ALL MEDICATIONS

Student's Name	Grade/Homeroom	Date of Birth

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER

Diagnosis/Reason for medication: _____

Name of medication: _____

Medication Form: _____tablet/capsule _____liquid _____inhaler _____injection

Special Storage Requirements: _____refrigerate _____none ____other_____

Start Date: _____ Stop Date: _____end of school year _____ other

_____ for episodic/emergency events only

Instructions/Schedule and dosage given:_____

Restrictions/Side Effects: _____

Adverse reactions that should be reported to the physician: _____

If prescribing an EPIPEN or RESCUE INHALER, is student capable and responsible for self-administering this medication _____yes _____supervised _____unsupervised _____ no
May student carry the EPIPEN or RESCUE INHALER _____yes ____no

Procedure to follow if medication does not produce expected relief: _____

_____

Date: _____ Signature:_____
Physician's (name printed): _____
Address: _____
Phone Number: _____ Emergency Phone Number: _____

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for _____ to receive the above medication at school or field trips according to school policy. It is understood that the school and its personnel are absolved from any responsibility, which may be associated with the administration of such medication. I understand that the medication must be brought to school in its original container or in the container to which it was dispensed by the pharmacist.
Date: _____ Signature of Parent/Guardian: _____
Address: _____ Phone: _____