MEDICATION AUTHORIZATION FORM

Dear Parents,

School District policy states that prescription medication may not be given to students in the school setting unless a written request from the parent and physician signature & verification in writing is received. Non-prescription medications require a written request from the parent.

Please complete and return this form along with the medication in an **Original** labeled container. The prescription medication label must include the **child's name**, **physician**, **name** and **dosage of the medication** and **route**. **Non-prescription** medications must be in an Original labeled bottle.

Each medication requires a separate medication form. If you have any questions, please contact the school office.

Name of Student:______________________________DOB:______________________Grade:_________________

List any Drug Allergies:____

Diagnosis:____Physician:_______________________________

Name of Drug:____

Dosage:____

Time of Day or Frequency of Use:____________________________________

Dates covered by this order:________________ to _________________

Possible side effects:____

Physician Signature:____

I request that the above medication be given at school as prescribed by our physician (if prescription) or by my permission (if non-prescription)

Parent Signature:____________________________________Date:_____________________________

RN Contacted: Signature:______________________________Date:_________________________

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