MEDICATION AUTHORIZATION FORM

Student's Name_____**Age**_____**Grade** _____

Doctor_____**Phone Number**_____**Pharmacy**_____

Name of Medication_____

Diagnosis (What is the medication for?)_____

_____

Amount to be given_____**Time to be given**_____

*****Is this medication to be given "as needed" OR at a specific time (please circle one)**

Starting date_____**Ending date**_____

Amount sent to school_____

I request that the prescribed drugs or medication be dispensed according to these written instructions. I request that a qualified staff person give this medication. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.

Parent Name_____**Parent Signature**_____

Date_____**Parent Phone Number**_____

MEDICATION WILL NOT BE GIVEN IF IT HAS EXPIRED OR IF IT HAS AN IMPROPER LABEL. PLEASE CHECK THE CONTAINER BEFORE SENDING IT TO SCHOOL.

SUGGESTION: WHEN YOU PICK UP YOUR PRESCRIPTION ASK YOUR PHARMACIST FOR A BOTTLE LABELED FOR SCHOOL USE.