

## Physician Authorization for Medication

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Grade: \_\_\_\_\_

City/Zip: \_\_\_\_\_

Name of Licensed Prescriber: \_\_\_\_\_ Title: \_\_\_\_\_

Business Telephone Number: \_\_\_\_\_ Emergency Number: \_\_\_\_\_

**I have determined that it is necessary for this medication to be administered during school hours.**

Medication to be administered: \_\_\_\_\_

Route: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency/time(s) of administration: \_\_\_\_\_

Other specific directions or information regarding this medication/administration:

Optional information:

1. Special side effects, contraindications, or possible adverse reactions to be observed:

2. Other medication being taken by this student:

3. The date of the next scheduled visit or when advised to return to prescriber:

4. Consent for self-administration, provided the school nurse determines it is safe and appropriate.

Yes: \_\_\_\_ No: \_\_\_\_

\_\_\_\_\_  
Signature of Licensed Prescriber

\_\_\_\_\_  
Date

## Parent Authorization for Medication Administration

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian name (print): \_\_\_\_\_

Phone Numbers: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Emergency: \_\_\_\_\_

Other person(s) to be notified in case of a medication emergency:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality):

Any special directions, signs to observe, side effects:

My son/daughter has the following food or drug allergies:

Date to discontinue medication: \_\_\_\_\_

Follow up visit to prescriber: \_\_\_\_\_

\_\_\_ I am requesting the school nurse or designated school personnel to administer the medication prescribed

by: \_\_\_\_\_ to \_\_\_\_\_  
(Licensed prescriber) (Student)

\_\_\_ I am requesting that the school nurse or designated person administer this over-the-counter (OTC), non-prescription drug according to the manufacturer's directions. \_\_\_\_\_

\_\_\_ I give permission for my son/daughter to self-administer medication, if the school nurse determines it is safe and appropriate.

\_\_\_ I request the above student receive this medication according to the prescription or parental request for OTC drug, and any special instructions. I understand the information is confidential according to the Family Rights and Privacy Act (FERPA), and school personnel, needing to know, have access to this information. I agree to coordinate and work with school personnel and the prescriber if questions arise. I understand I may cancel this request at any time, and/or retrieve the medication from the school at any time. I understand the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_