AUTHORIZATION FOR MEDICATION TO BE TAKEN DURING SCHOOL

Student Name____ Grade_________

I give permission to have the school nurse or school personnel designated by the school nurse to give medication listed below to my child as directed by his/her physician. If indicated below, I give permission for him/her to self medicate as instructed and authorized by his/her physician.

Parent/Guardian__________________________________Date_____________

Home Phone_______________Emergency Phone____________________

The Following is to be completed by the prescribing PHYSICIAN

Diagnosis_______________________________________

Medication______________________________________

Dose__________________Route of adminstration_______________________

Frequency_________________Time of Adminstration_____________

If as needed, describe indications_______________________________

Consent for self administration (provided the school nurse determines it is safe and appropriate)

Yes__________No________________

Side Effects____

Date of order___________________Discontinuation Date_____________

Physican__________________________________Date____________

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