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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