

MEDICATION AUTHORIZATION

*NOTE: Fields marked with an * must be completed by a **healthcare provider** for prescription medication.*

*Medication's name: _____

*Relevant diagnosis: _____

Dates medication must be provided at school:

Short term, list dates to be given: _____

Every day at school until:

Medication is gone End of the school year Other: _____

Episodic/Emergency Events ONLY (explain): _____

*Dosage (amount) _____ *Route _____ *Form _____

Time(s) of day*: _____

NOTE: If request is to provide medication after school hours when the student is under district supervision, the parent/guardian must work with the building Principal to develop a plan for coordinating this request.

*Serious reactions/adverse side effects from this medication may occur: Yes No

*If yes, describe: _____

*Action/treatment for reactions:

*Special handling instructions: Refrigeration Keep out of sunlight

Other: _____

*Is any dispensing equipment or other medical equipment required in order for the student to receive medication? Yes No

*If yes, describe equipment and any special storage instructions: _____

HEALTHCARE PROVIDER'S AUTHORIZATION

NOTE: This consent is only required for:

A. Prescription medication

B. Over-the-counter medication if it is to be provided in a manner inconsistent with manufacturer's recommendation.

*I certify that the information contained on this form is accurate and complete to the best of my knowledge.

Healthcare provider's name (print)

Healthcare provider's signature

Date