MEDICATION AUTHORIZATION

School____Grade__________Room______

Student Name____

(date of birth)

Address______________________________Home Phone No.____________________

I understand that special permission is required for the use of medication by students during school hours. I request that my child be given the medication described below or be permitted to self-carry/self-medicate by me and my physician.

____

(Parent/Guardian Signature) (Date)

____

This Section To Be Completed By Physician

Medication____Daily________PRN______

Dose____________Route__________Time__________Freguency______________

Describe Indications____

Side Effects____

Related Diagnosis___________________________Allergies____________________

Other Information____

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Is medication needed on a field trip or activity away from school: Yes_ No_

This child is authorized to self-carry and/or self-medicate in school, on a field trip, or activity away from school (excludes controlled substances). Yes_____ No____

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(Physician Signature) (Date)