PARENT AND PHYSICIANS AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND DURING SCHOOL ACTIVITIES

Name of Student_____ DOB _____
Diagnosis_____

A. To be completed by physician:
I request that my patient, as listed above, receive the following medication:

MEDICATION	DOSAGE	FRQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

DURATION OF TREATMENT __ 20__/20___ school year (including summer sessions)
__ other

**Please note medications will not be administered on early release days, with exception of emergency medication, procedures and treatments.*

Possible Side Effects and Adverse Reactions (if any)_____

PLEASE CHECK ONE:
__ **I deem this child to be NON SELF-DIRECTED** and understand that administration of oral, topical, inhalation and injectable medication must remain the responsibility of the school nurse, physician or parent.
__ **I deem this child to be SELF-DIRECTED** and understand that the school nurse, or other designated person in case of the absence of the school nurse (including field trips) will supervise administration of medication.
__ **I deem this child may SELF-ADMINSTER and SELF CARRY** their own medication with approval of the school nurse.

Physician signature_____ **Date** _____
Address_____ Phone _____

B: To be completed by the Parent or guardian:
I have consulted with my child's physician and agree with his/her recommendations. I request my child receive the medication as prescribed above by our physician. The medication is furnished by me in the properly labeled container from the physician.
Parent signature_____ **Date** _____
Telephone #_____Cell #_____Work# _____

Nurse Signature_____ **Date** _____