# PARENT AND PHYSICIAN 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:

| Rx MEDICATION | DOSAGE | FREQUENCY/TIME TO BE TAKEN | ROUTE OF ADMINISTRATION |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**DURATION OF TREATMENT** __ 2024/2025 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-ADMINISTER 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** _____