PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND DURING SCHOOL SUMMER PROGRAMS

A. This section to be completed by parent or guardian:

I request that my child receive the medication as prescribed below by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse (or in her absence, a designated person) will administer the medication.

Student's Name:	**DOB:**	**Grade/ School:**
Parent/Guardian:		
Address:		
Telephone: Home:	**Cell:**	**Work:**
Signature: Parent/Guardian		**Date:**

B. This section to be completed by the licensed health care prescriber:

I request that my patient, as listed above, receive the following medication:

Name of Student:	
Diagnosis:	
Medication, Dosage and Route:	
Frequency / Time to be taken during school hours:	
Duration of Treatment:	
Possible Side Effects:	
Name of Licensed Prescriber:	
Prescriber's Signature:	
Address:	