Print Form

AUTHORIZATION FOR MEDICATION

Name of Student: _____ DOB: _____ Grade: ____

School: _____

Phone Number: _____ Fax Number: _____ Date: _____

MEDICATION TREATMENT PLAN TO BE COMPLETED BY PHYSICIAN

Diagnosis: _____

_____

Medication, Dosage, Specific Times and Directions for Administration (Please write each medication, dosage, frequency and time separately): _____

_____

_____

NOTE: Medication must be supplied in the original prescription container. Ask pharmacist to divide the medication into two completely labeled containers, providing one for home and one for school.

Side Effects/Special Instructions: _____

_____

_____

NOTE TO PHYSICIANS: Please complete the treatment plan on the next page of this form for students who require any special health procedures during school hours (i.e. inhalers, nebulizer treatments, catherization, suctioning, tube feedings, glucose testing, etc.).

Printed Name or Stamp of Physician: _____

Physician's Signature: _____

Physician's Phone Number: _____

Physician's Fax Number: _____

PARENTAL PERMISSIOIN TO BE COMPLETED BY PARENT/GUARDIAN

I grant the Principal or his/her designee the permission to assist in the administration of each prescribed medication/procedure to be provided during the school day, including when

_____ is away from school property on official school business
(Name of Student)

Signature of Parent: _____ Date: _____

Home Phone Number: _____ Work Phone: _____

Treatment for Students Needing Health Procedures During School Hours

Treatment Plan:_____

_____

_____

_____

_____

Special Procedures: List special procedures in which students have been trained (i.e. insulin administration, use of Epi-Pen, nebulizer, testing glucose levels, etc.):_____

_____

_____

_____

_____

_____

_____

Please list any limitation that should be considered (i.e. physical education, outdoor activities, etc.):

_____

_____

_____

_____

Please state the emergency precautions that should be considered (i.e. allergy triggers, diabetic reactions, etc.):

_____

_____

_____

_____

Physician's Signature_____Date_____