AUTHORIZATION FOR PRESCRIPTION MEDICATION OR TREATMENT

Part A: To be completed by the physician

Name of Student: ______________________________ DOB: ______________

Street ______________________ P. O. Box ______________

City ______________________ State ______________ Zip ________

School: ______________________________

I have prescribed the following:

Medication/Treatment ______________________________

Dosage ______________________________

Time to be given at school ______________________________

If **Asthma inhaler** may student carry on person: ______________

If **Epi-pen** may student carry on person: ______________

Is student trained to self administer medication? ________ Yes ________ No

Begin Date: ______________ End Date: ____________________

Side effects, Instructions, or precautions:

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____

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______________________________ ______________________
Physician's Signature Date

____
Telephone

____
Printed/Typed Name

____
Fax

Part B: To be completed by the Parent /Guardian

I request authorized school personnel to follow the medical instructions requested in PART A. I agree to see that the medication is delivered to the school: to notify the school if there is a change in physicians: to notify the school if the medication, dosage, or procedure is changed or discontinued. I give my consent to the physician, school nurse, or their designees to send and/or receive information related to my child's health as they deem appropriate for the duration of this order as noted above.

***Please note medication must be in pharmacy labeled bottle.**

DATE ________ Signature of parent/Guardian ______________________________

****Note: Please pick up all medications at the end of the school year. They will be destroyed if they are not picked up Revised 09/14/11