

PHYSICIAN'S REQUEST FOR MEDICATION TO BE GIVEN AT SCHOOL

(This section to be completed by the parent or guardian.)

Name of Student \_\_\_\_\_ Birthdate \_\_\_\_\_

Student's Address \_\_\_\_\_

School District \_\_\_\_\_ School \_\_\_\_\_

Grade \_\_\_\_\_ Homeroom No. \_\_\_\_\_ Homeroom Teacher \_\_\_\_\_

PARENT/GUARDIAN AUTHORIZATION FORM

School personnel approved by the Board of Education are herewith authorized to administer the medication or procedure as instructed by the physician.

I request school personnel administer the medication as instructed and agree to:

1. Deliver the medication that is required for dispensation during school hours in the original container which was provided by the prescribing physician or licensed pharmacist
2. Deliver written notification (by the next school day) to the school by a physician if the medication, the dosage, or the procedure is to be changed or eliminated.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Telephone No. During School Hours \_\_\_\_\_ Other Telephone No. \_\_\_\_\_

(This section to be completed by the physician.)

PHYSICIAN'S AUTHORIZATION AND INSTRUCTIONS

Physician's Name \_\_\_\_\_ Date \_\_\_\_\_

Physician's Phone \_\_\_\_\_ Emergency Number \_\_\_\_\_

Name of Medication to be given \_\_\_\_\_

Dosage \_\_\_\_\_

Time(s) Medication is to be given \_\_\_\_\_

Length of time Medication is to be given \_\_\_\_\_ to \_\_\_\_\_  
(beginning date) (ending date)

Special instructions regarding medication \_\_\_\_\_

List adverse reactions that should be reported to physician \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

[Adoption date: August 6, 1991]

Revised: October 20, 1993  
April 16, 1997  
September 17, 2014