Physician and Parent Medication Authorization Form

NAME OF STUDENT _____ DOB ___/____/_____

THE MEDICATION LISTED BELOW **MAY NOT** BE SCHEDULED FOR OTHER THAN SCHOOL HOURS.

I request that the school nurse/UAP or other designated person administer medication as directed by the physician. I authorize the school nurse/UAP to communicate with the prescribing physician when the school or physician wants more information about school asthma symptoms or management, or other applicable needs that pertain directly to the health of my child. I agree to save and hold the district, its officers, employees or agents harmless from liability, suits or claims, of whatever nature or kind which might arise as a result of administering the medication in accord with this request.

Each student's medication is required to have the following:

- Affixed Prescription Label
- Child's Name
- Name of Drug
- Dosage
- Number of tablets, capsules or puffs
- Volume of liquid
- Time of Administration
- Route

Medication: _____ Dosage: _____ Time: _____

Allergies: _____

Condition for which medication is prescribed: _____

Observation/Special Instructions: _____

_____

_____ _____

Parent's Signature Date

Physician's Signature Date

Home Telephone: _____

Emergency number: _____

Physicians Name: _____

Telephone Number: _____

Fax Number: _____

School Nurse Use:

Filed in clinic:
By: _____
Date: _____