Authorization for Medication Administration

Medication must be sent home at the end of the year (*circle preferred method***)**:

1. Home with student 2.Parent will pick up 3.Dispose of medication

Date: _____

Students Name: _____ ID: _____ Birth Date: _____

School: _____ Grade: _____ Teacher: _____ Gender M/F

Home/Cell Phone: _____ Emergency Phone: _____

Name of Medication: _____

Dosage (including route of administration) _____

Scheduled Time to be given: _____ or PRN: (as needed) Will be given per label directions.

Diagnosis for which medication is prescribed: _____

Do not administer after the following date: _____ or end of current calendar school year

I authorize the physician named below to release information regarding medication my child will take during school hours, to PfISD Health Services Department.
I request that the designated personnel of the above school district administer medication to my child, named above, according to written physician's instructions and authorize the school nurse to exchange information with the physician or their authorized representative regarding medication and health related issues. I understand it is my parental/guardian responsibility to furnish an adequate supply of this medication in the original and properly labeled container. I understand that school district personnel will protect my child by not administering the medication if this form is not complete, the physician's authorization is not complete, or the prescribed medication is not provided.

Parent/Guardian Printed Name: _____ Parent/Guardian Signature: _____

****** If medication is to be administered more than 10 consecutive days, a physician must complete and sign below. *******

Diagnosis for which medication is prescribed: _____

If asthma inhaler and no response to treatment -may repeat interval: _____ dose: _____
(Please provide Asthma Action Plan)

Side effects: _____

Physician Signature: _____ Date: _____

Physicians Name: _____

Office Address: _____

Physician Phone: _____ Physicians Fax: _____

Received by: _____ Date: _____