

Health Care Provider's Signature \_\_\_\_\_

## Authorization to Administer <u>Prescription Medication</u>

Student	· · · · · · · · · · · · · · · · · · ·	Birth date
School	Grade	School Year
Parent/Guardian 1:	Parent/Guardi	an 2:
Daytime Phone ()	Daytime Phor	ne ()
Cell ()	Cell ()_e end of the school year or	following the summer school session.
between school district personnel and the writing at the withdrawal of this request of  I understand that it is my responsibility  Transport the medication to so  Replace the supply of medication  Pick up medication or direct staff	p receive the medication listed below. In health care provider, if necessary, regains when a change in this medication occurs to:    hool in the original pharmacy-labeled of the when needed for the discard remaining medication upon continuous process.	
	vider's Order for Medicat	
Medical Condition:		
Name of Medication: (generic and trade)		
Dosage of Medication:	mg / cc / tsp drops / puffs	Form:   Tablet / Capsule   Liquid  Inhaler   Other
Route:	□ Oral □ Eyes □ Ear □ Nos	se □ Topical □ Rectal □ Other
Administration Time:	□ Daily at:  □ As needed - Describe frequency &  □ May be repeated in	symptoms for which medication should be given:
Possible Side Effects:		
For inhaled asthma medication ONLY:	medication by him/herself.	s student should be allowed to carry and use this s student <u>SHOULD NOT</u> carry this medication by
<b>Health Care Provider's Name</b> (Please p	rint)	Phone (

\_\_\_\_\_Date \_\_\_\_\_

## FOR SCHOOL USE

lame of nanco	n(s) who will administer the Me	edication:
name of perso	in(s) who will dominister the Me	culculton.
<del>, , , , , , , , , , , , , , , , , , , </del>		
Approved by: _		