PHYSICIAN AUTHORIZATION AND PARENTAL REQUEST FOR *ALL* MEDICATIONS

_____ _____ _____

Student's Name Grade or Homeroom Date of Birth

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER

Diagnosis/Reason for medication: _____

Name of medication: _____

Medication form: ___tablet/capsule ___liquid ___inhaler ___injection ___other: _____

Special Storage Requirements: ___refrigerate ___none ___other: _____

Start date: _____ Stop Date: ___end of school year ___other/duration _____

_____for episodic/emergency events only

Instructions (schedule and dosage to be given) _____

_____

Restrictions/side effects _____

Adverse reactions that should be reported to the physician _____

_____

If prescribing an **EPIPEN** or **RESCUE INHALER**, is student capable and responsible for self-administering this Medication? ___No ___Yes (supervised) ___Yes (unsupervised)

May student carry the Epipen or Rescue Inhaler? ___yes ___no

Procedure to follow in event medication does not produce expected relief _____

_____

Date: _____	Signature: _____ Authorized prescriber

Physician's name printed: _____

Address: _____

Phone number: _____ Emergency number: _____

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for my child, _____ to receive the above medication at school or field trips according to _____ School policy. It is understood that _____ and all of its personnel are absolved from any responsibility, which might be associated with the administration of such medication. I understand the medication must be brought to school in its original container or the container to which it was dispensed from the pharmacist.

Date: _____ Signature of Parent/Guardian: _____

Address: _____ Phone number: _____

Reviewed by Nurse (name): Date: