MEDICATION AUTHORIZATION

PHYSICIAN FORM

Specify one medication per form

DATE: _____

Permission is granted for school employees (as designated by school principal) to administer medication as follows:

STUDENT: _____ BIRTH DATE: _____

MEDICATION NAME: _____

DOSE: _____ METHOD OF ADMINISTRATION: _____

TIME/FREQUENCY: _____ DURATION: _____

DIAGNOSIS: _____

PRECAUTIONS, INTERVENTIONS, COMMENTS: _____

_____

_____

_____

I am willing to be contacted by school personnel with concerns or questions involving this medication's administration.

If the medication is injectable, school personnel (as designated by the principal) who have been trained in techniques of administering subcutaneous or intramuscular injections have permission to administer the injectable medication.

Medications must be brought to school in the original container by a responsible adult.

Please print:

_____ _____ _____

Physician's Name Phone # Fax #

_____

Address

_____

City, State, ZIP

_____ _____

Physician's Signature Date