

**PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF  
MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES**

**A. To be completed by the parent or guardian:**

I request that my child \_\_\_\_\_ DOB \_\_\_\_\_ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy\*.

Signature(Parent or Guardian): \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Date \_\_\_\_\_

**B. To be completed by physician:**

I request that my patient, as listed below, receive the following medication:

Name of Student \_\_\_\_\_ DOB \_\_\_\_\_

Diagnosis: \_\_\_\_\_

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment:

Possible Side Effects and Adverse Reactions (if any):

**PLEASE CHECK ONE :**

- I deem this child to be **self directed** and understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips.
- I deem this child to be **non self-directed** and understand that administration of oral, topical, inhalant and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

Physician's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

- \* Medication must be in original pharmacy labeled container with specific orders and name of medication.
- \* Medication and refills must be brought to school by parent, guardian or responsible adult.

**Plan reviewed with parent(s)/guardian(s):**

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_