AUTHORIZATION FOR MEDICATION

ONE MEDICATION PER FORM

SCHOOL YEAR: 20____20____

STUDENT'S PICTURE

Student's Name _____ Date of Birth _____ Grade _____

School Name _____ Phone Number _____ Fax Number _____

TREATMENT PLAN (To be completed by Medical Provider)

Diagnosis: _____

ALLERGIES: _____

Medication/Strength/Route: _____

Dose & Frequency: _____

Directions: _____

_____

Side Effects: _____

Has student been trained in the use _____ (medication's name) Yes ☐ No ☐

Is student authorized to carry *and* self-administer _____ (medication's name) Yes ☐ No ☐

I am aware that this medication may be administered by school personnel/non-medical staff.

Provider's Name (PLEASE PRINT/STAMP) _____ Signature _____ Date _____

Address _____ Phone _____ Fax _____

PARENTAL/GUARDIAN PERMISSION

I, _____, give my permission to the School Principal or his/her specified
Parent/Guardian Name (PLEASE PRINT)

delegated personnel to administer prescribed medication to: _____.
(Student's name and Relationship)

Signature of Parent/Guardian _____ Phone _____ Date _____