Authorization to Administer Medication at School

Name of Child: _____ Date of Birth: _____

Site: _____ Phone: ( ) _____

MANDATORY: The PHYSICIAN must complete line items 1 - 8. (Missing items may affect child's program participation)

1) Please List Allergies and/or Medical Condition: _____

2) Medication **Generic** Name (No Brand Names)	**3)** When to take (i.e. Symptoms)	**4)** Dosage **AND** Frequency	**5)** Possible Side Effects **AND** Intervention Instructions

6) Begin Date of Medication: ____ / ____ / ____ **7)** End Date of Medication (**If applicable**): ____ / ____ / ____

8) Physician Signature/Date and Contact Information (or Official Stamp):

Name (print): _____

Signature: _____ Date: _____ / _____ / _____

Office phone #: (____) _____ Office Fax #: (____) _____

Physician/Clinic Address (print): _____

The following is to be completed by the PARENT after the above has been completed by the physician

PARENT AUTHORIZATION TO ADMINISTER MEDICATION AT SCHOOL

- ✓ I hereby authorize school staff to administer the inhaled and/or non-inhaled medication described above to my child.
- ✓ I understand that the teacher or school staff will administer only the medication described above.
- ✓ If the prescription is changed, a new form for parental consent with the physician's prescription and signature must be completed before any school staff will be able to administer the new medication.
- ✓ I also understand that the medication label and directions on the label must match the physician's prescription from this form.
- ✓ I understand that all medication must be delivered to the site in the original pharmacy container.

Print Name of Parent/Guardian: First _____ Last _____

Signature of Parent/Guardian _____ Date _____ /_____ /_____

Parent / Guardian Address: _____

Parent / Guardian Phone number _____