

## MEDICATION AUTHORIZATION FORM

Student's Name \_\_\_\_\_ Age \_\_\_\_ Grade \_\_\_\_ Teacher \_\_\_\_\_

Physician/Dentist \_\_\_\_\_ Phone Number \_\_\_\_\_

Pharmacy \_\_\_\_\_

Name of Medication \_\_\_\_\_

Diagnosis (What is the medication for?) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Amount to be given \_\_\_\_\_ Time to be given \_\_\_\_\_

Is this medication to be given "as needed" ☐ OR at a specific time ☐ (please check one)

Starting date \_\_\_\_\_ Ending date \_\_\_\_\_

Amount sent to school \_\_\_\_\_

**I request that the prescribed drugs or medication be dispensed according to these written instructions. I request that a qualified staff person give this medication. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.**

Parent signature \_\_\_\_\_ Date \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**MEDICATION WILL NOT BE GIVEN IF IT HAS EXPIRED OR IF IT HAS AN IMPROPER LABEL.  
PLEASE CHECK THE CONTAINER BEFORE SENDING IT TO SCHOOL.**

**SUGGESTION: WHEN YOU PICK UP YOUR PRESCRIPTION ASK YOUR PHARMACIST FOR A  
BOTTLE LABELED FOR SCHOOL USE.**