PARENT AND HEALTHCARE PROVIDER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

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.*

Parent Signature ________________________________ Date_____________________

B. **To be completed by the Private Healthcare Provider**:

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

Student's Name_______________________________________ DOB_______________

Diagnosis____

Medication____

Dosage_________________Route______________________Frequency____________

Time to be taken during school hours__________________________

Possible side effects or adverse reactions (if any):

____

Health Care Provider's
signature:____Date___________________

Physician Information: (Please Stamp)

This medication order is valid for SCHOOL YEAR 2024-2025

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