APPENDIX B
SAMPLE AUTHORIZATION FORM

PARENT AND PRESCRIBER'S AUTHORIZATION FOR
ADMINISTRATION OF MEDICATION IN SCHOOL

Authorization for Administration of Medication

A. To be completed by the parent or guardian:

I request that my child _____ grade _____ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication or an adult will supervise my child taking his/her own medication.:

Signature (Parent or Guardian):_____

Address:_____

Telephone: Home _____ Work_____ Date:_____

B. To be completed by the licensed health care prescriber:

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

Name of student:_____ Date of Birth:_____

Diagnosis:_____

Name of Medication:_____

Prescribed Dosage, Frequency and Route of Administration:_____

_____

Time to be Taken During School Hours:_____

Duration of Treatment:_____

Possible Side Effects and Adverse Reactions (if any): _____

_____

Other Recommendation: _____

_____

Name of Licensed Prescriber and Title (please print): _____

Prescriber's
Signature:_____ Date: _____

Address:_____ Phone:_____