



**Prescription Medication Authorization  
REQUIRED ANNUALLY**

**School year:** \_\_\_\_\_

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Time to be given at school: \_\_\_\_\_

Diagnosis/Medical reason for medication(s): \_\_\_\_\_

Effective Date: \_\_\_\_\_ Method of administration: \_\_\_\_\_

Other Instructions: \_\_\_\_\_

\_\_\_\_\_

Print Medical Provider Name: \_\_\_\_\_ Clinic: \_\_\_\_\_

Phone number: \_\_\_\_\_

Physician/Medical Provider Signature: \_\_\_\_\_

**PARENT/GUARDIAN AUTHORIZATION (required ANNUALLY)**

1. I request that the above medication be given during school hours as ordered by the student's medical provider.
2. I will notify the school of any changes in the medication, i.e. dosage change, medication is discontinued.
3. I give permission for school personnel to communicate with teachers about the dosage, action, and side effects of the prescribed medication.
4. I understand that I must bring the medication to school in a properly labeled bottle and will pick up any unused medication at the end of the school year or it will be disposed of on the last day of school.
5. I give permission for school personnel to consult with the above named student's physician regarding any questions that arise with regard to the listed medication or medical condition being treated by this medication.

Signature of parent/guardian \_\_\_\_\_ Date: \_\_\_\_\_