Medication Prescriber/Parent Authorization Form
(Preschool through 8th grade)

Student Name:_____Birthdate:_____Teacher:_____Grade_____School Year_____

To be completed by physiscan /licensed prescriber:

	Medication Name	Dose	Time to be given	Form/Route*	Side Effects	Adverse Reactions
1						
2						

* Routes~oral (pill/capsule/chewable, liquid) ~ inhaled (inhaler, nebulizer) ~ topical skin application ~ topical (eye drop, ointment) ~ topical eare drop~ injection ~ other (list)

List minimal frequency between doses (especially if p.r.n.):_____

If p.r.n., list symptoms /conditions under which medication is to be given:_____

Reason for medication (optional): Medication # 1_____Medication # 2_____

Special instructions:_____

Start date if not beginning of the school year:_____ Stop date if not end of the school year:_____

_____

Physician's signature Date Physician's printed name

Physician's Phone # _____ Fax #_____ Address:_____

To be completed by parent/guardian:

I request and give permission for (name of child)_____to receive the above medication(s)/treatment at school according to standard school policy and for the physician('s)/staff and school staff information needed to assist my child with medication needs. (Schools requires parent/guardian to bring medication in its original container).

_____

Parent/guardian signature Date