Authorization for Medication

Date: _____

Student Name: Last, First, Middle	Date of Birth	Grade

MEDICATION TREATMENT PLAN TO BE COMPLETED BY PHYSICIAN

Diagnosis: _____

Medication, Dosage, Specific Times and Direction for Administration: _____

Note: Medication must be supplied in the original prescription container. Ask the pharmacist to divide the prescription in two completely labeled containers, one for home and one for school.

Side Effects/Special Instructions: _____

Note to Physicians: Please complete the treatment plan on the back of this form for students who require any special health procedures during school hours (e.g. inhalers, nebulizer treatments, glucose testing, etc.)

Printed Name of Physician	Physician's Signature
Physician's Phone Number	Physician's Fax Number

PARENTAL PERMISSION

I grant the principal or his/her designee the permission to assist in the administration of each prescribed medication/procedure to be provided during the school day, including when

Name of Student _____

is away from school property on official school business.

Signature of Parent	Date	Home Phone/Work Phone/Cell

Name of Student: _____ Grade: _____

TREATMENT FOR STUDENTS NEEDING HEALTH PROCEDURES DURING SCHOOL HOURS

Treatment Plan: _____

_____

_____

Special Procedures (List special procedures in which students have been trained; e.g. insulin administration, testing glucose, etc.): _____

_____

_____

Please list any limitations/precautionary measures that should be considered (e.g. physical education, outdoor activities, transporting, and lifting, special devices/equipment): _____

_____

_____

_____

Please state any emergency precautions/health emergencies that should be anticipated for this student (e.g. allergy triggers, diabetic reactions, etc.) _____

_____

_____

What is the care plan for these identified emergencies? _____

_____

_____

_____ _____

Physician's Signature Date