MEDICATION/TREATMENT AUTHORIZATION FORM

Name of Student ______________________________ Birth Date _____________

School ____ Grade _____

SECTION I

To be completed by the physician or licensed health care provider on all medications (REQUIRED)

Diagnosis / Purpose of medication / treatment (optional) ____________________________

Name of medication / treatment ______________________________________

Dosage __________ Frequency ____________ Time __________ Route __________

Start date ______________Stop date _________________ Indefinite ____________

Instructions, adverse reactions, storage requirements, etc. ___________________________

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Physician's signature ______________________________ Date ________________

Physician's Name (print) ____________________________

Physician's Address ____

SECTION II

To be completed by Parent/Guardian (REQUIRED)

Medications and treatment supplies will be brought to school by the parent/guardian unless other safe arrangements are necessary and possible. All medication should be kept in a labeled container as prepared by a pharmacy, physician or pharmaceutical company and labeled with the student's name, route, dosage and frequency. The prescription renewal and medication/treatment supply shall be the responsibility of the parent/guardian.

The student is responsible for presenting himself/herself on time and for taking the medication as prescribed. The undersigned parent/guardian shall notify the school district in writing in the event the prescription shall be discontinued.

I request that the medication/treatment be administered in conformance with the physician/licensed health care provider directions and according to the School District's policy. I give permission for the physician/healthcare provider/staff and school district staff to share information needed to assist my child with medication needs.

Parent/Guardian Signature ____________________________ Date ____________