MEDICATION AUTHORIZATION

*NOTE: Fields marked with an * must be completed by a healthcare provider for prescription medication.*

*Medication's name: _____

*Relevant diagnosis: _____

Dates medication must be provided at school:
☐ Short term, list dates to be given: _____
☐ Every day at school until:
☐Medication is gone ☐End of the school year ☐Other:_____

☐ Episodic/Emergency Events ONLY (explain): _____
_____
_____

*Dosage (amount) _____ *Route _____ *Form _____
Time(s) of day*: _____
_____

NOTE: If request is to provide medication after school hours when the student is under district supervision, the parent/guardian must work with the building Principal to develop a plan for coordinating this request.

*Serious reactions/adverse side effects from this medication may occur: ☐Yes ☐ No
*If yes, describe:_____
_____
_____

*Action/treatment for reactions:
_____

*Special handling instructions: ☐Refrigeration ☐Keep out of sunlight
☐Other: _____

*Is any dispensing equipment or other medical equipment required in order for the student to receive medication? ☐Yes ☐ No
*If yes, describe equipment and any special storage instructions: _____
_____
_____

HEALTHCARE PROVIDER'S AUTHORIZATION

NOTE: This consent is only required for:

A. Prescription medication
B. Over-the-counter medication if it is to be provided in a manner inconsistent with manufacturer's recommendation.

*I certify that the information contained on this form is accurate and complete to the best of my knowledge.

_____
Healthcare provider's name (print)

_____ _____
Healthcare provider's signature Date