AUTHORIZATION FORM FOR PRESCRIPTION MEDICATION

Student Name: _____ DOB_____ YOG_____ School Year_____

PART I: TO BE COMPLETED BY A **PHYSICIAN**:

Date of Order:_____

Diagnosis:_____

Medication:_____

Dose:_____ Frequency:_____ Route:_____

Time of Administration: _____ Duration of Administration:_____

Possible Side Effects: _____

_____ _____

Physician's Signature Office Phone Number

_____ _____

Physician's Printed Name Office Fax Number

PART II: TO BE COMPLETED BY **PARENT/GUARDIAN:**

I assure that the first dose of this medication has been given without adverse effects and request that the school nurse administer the above medication, as prescribed by our physician to my daughter, _____.

_____ _____

Parent/Guardian Signature Date