



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