Revised 1/04

PHYSICIAN/PARENT AUTHORIZATION FORM
FOR **PRESCRIPTION** MEDICATION/TREATMENT

Student's name (last) ____ (first) ____ (M.I.) ____ (DOB) ____ (YOG) ____ (school year) ____

Part 1: TO BE COMPLETED BY A PHYSICIAN:

Date of order: ________________________________
Diagnosis: ________________________________
Medication: ________________________________Dose: ______________
Time of administration at school: ______________ Route: ____________
Duration of administration: ________________________________
Possible side effects: ________________________________
Reason for medication: ________________________________
If PRN for what symptoms? ________________________________

(For inhaler and epi-pen medication only:)

____ It has been determined that this student is able to self-administer and carry inhalant medication or Epi-pen and has been trained in its' use including knowing when the medication is to be used.

____ This student should not self-administer inhalant medication or Epi-pen. Student has not demonstrated ability to self administer.

________________________________ ________________________________
Physician's Signature Office Phone

________________________________ ________________________________
Physician's name printed Physician's fax #

PART 11 TO BE COMPLETED BY PARENT/GUARDIAN:

I assure that the first dose of this medication has been given without adverse effects and request that a TCHS nurse or her designee administer the above medication, as prescribed by our physician, to my child, ________________________________.

The exception to first dose of medication being given at home would be the use of Epi-pens only!*

________________________________ ________________
Parent/Guardian signature Date