Administrative Procedure 325 – Appendix A

PRESCRIBED MEDICATION FORM

Student: _____ Grade: _____

Date of Birth: _____ School: _____

Name of Family/Agency: _____

Home Address: _____

Telephone: (Home) _____ (Work) _____

REQUEST AND AUTHORIZATION:

I hereby authorize and request the administration of the following prescribed medication for my child,

_____*, by non-medically trained staff at* _____*School.*

Date: _____ Signature: _____

Name of Student's Doctor: _____ Telephone: _____

Name of Student's Pharmacist: _____ Telephone: _____

Medication Prescribed	**Dosage**	**Side Effects**
1.		
2.		

Other Pertinent Information (time of day, 2 weeks, etc.):

_____

_____

Annual Validation

This authorization is valid from _____ to _____
(maximum of 12 months)

NOTE: Parents may be requested to provide pertinent written medical data to be obtained from the pharmacist before the administration of medication can occur. (e.g. information sheets on specific medication)

I hereby acknowledge receipt of a copy of this form.

Signature of Student's Physician: _____
Date: _____

NOTE:
1. Families/agencies are required to contact the principal of the school if there is a change in medication and/or dosage.
2. It is expected that only small quantities of medication will be sent to school.