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: ____________________

<u>**Medication Prescribed**</u> <u>**Dosage**</u> <u>**Side Effects**</u>

1. ____
2. ____

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

____

____

<u>Annual Validation</u>

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.