



**PARENT AND HEALTHCARE PROVIDER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES**

**A. To be completed by the Parent or Guardian:**

I request that my child \_\_\_\_\_ (Date of birth: \_\_\_\_\_) receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy\*.

Signature(Parent or Guardian): \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Date \_\_\_\_\_

**B. To be completed by the Private Healthcare Provider:**

I request that my patient, as listed below, receive the following medication:

Name of Student \_\_\_\_\_ DOB \_\_\_\_\_

Diagnosis: \_\_\_\_\_

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Possible Side Effects and Adverse Reactions (if any):

Healthcare Provider's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\* Medication must be in original pharmacy labeled container with specific orders and name of medication.  
 \* Medication and refills must be brought to school by parent, guardian or responsible adult.

This medication order is valid for the current school year as needed.