# ELEMENTARY MEDICATION FORM

AUTHORIZATIONS FOR SCHOOL ADMINISTRATION

*All prescriptions, INCLUDING over-the-counter medications, must have orders written by a medical provider for administration at school.*

**STUDENT NAME:**

**DOB:**

**GRADE:**

## TO BE COMPLETED BY PARENT OR GUARDIAN

I request that my child receive the medication(s) as prescribed below by my child's medical provider. Medications will be furnished by me in the properly labeled, original container(s), from the pharmacy/store.

Parent/Guardian Printed Name:

Daytime Contact Phone Numbers:  
(W)  
(C)  
(H)

Parent/Guardian Signature:  
Date:

## TO BE COMPLETED BY HEALTH CARE PROVIDER

I request that my patient, as listed above, receive the following medication(s):

<table>
<thead>
<tr>
<th>MEDICATION(S)</th>
<th>DOSAGE/ROUTE</th>
<th>FREQUENCY/TIME</th>
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<tbody>
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Reason for medication(s):

Duration of Treatment:

Possible Side Effects/Adverse Reactions:

Health Care Provider’s Signature:  
Date:

Health Care Provider’s Printed Name or Stamp:

Address:  
Phone:

*April 2020*