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):

MEDICATION(S)	DOSAGE/ROUTE	FREQUENCY/TIME

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: