

**PARENT AND PRESCRIBER'S AUTHORIZATION FOR  
ADMINISTRATION OF MEDICATION IN SCHOOL**

**Authorization for Administration of Medication**

A. To be completed by the Parent of Guardian:

I request that my child \_\_\_\_\_ grade \_\_\_\_\_  
Receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse or other designated person, in the case of the absence of the school nurse, will administer the medication.

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

Telephone #: \_\_\_\_\_ Date: \_\_\_\_\_

B. To be completed by the licensed health care prescriber:

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

Name of Student: \_\_\_\_\_ Date of Birth \_\_\_\_\_

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

Name of Medication: \_\_\_\_\_

Prescribed Dosage and Means of Administering: \_\_\_\_\_

\_\_\_\_\_

Time to be Taken During School Hours: \_\_\_\_\_

Expected Duration of Treatment: \_\_\_\_\_

Possible Side Effects and Adverse Reactions (if any): \_\_\_\_\_

\_\_\_\_\_

Other Recommendations (including PRN or self-administration orders): \_\_\_\_\_

\_\_\_\_\_

Name and title of Licensed Prescriber (please print): \_\_\_\_\_

\_\_\_\_\_