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

Patient may carry/ administer inhaler for asthma Yes____ NO_____
Patient may carry EPI-PEN Yes___ NO_____

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