PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by the parent or guardian:

- I give permission for my child _____ DOB _____ to be given and/or self-administer the medication listed below as prescribed by a licensed health care provider while at school, and/or school sponsored activities.
- I understand that if it is determined that my child is self directed, (knows the name, dosage, frequency and indication for use of the medication) the teacher may carry the medication but is not responsible for administration.

Parent/Guardian Signature: _____ Date: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

B. To be completed by physician:

I request that my patient, _____, DOB: _____receive the following medication:

Medication	Dose	Route	Time to be taken	Indication for use	Start Date	Duration of order	Possible side effect
May self administer		Yes/No					
May carry on self		Yes/No					

FIELD TRIPS:

_____ Omit the medication on the day of the field trip for the school year.

_____ The time may be adjusted around the field trip if needed.

Physician'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.

Plan reviewed with parent(s)/guardian(s):

Parent/Guardian signature: _____ Date: _____