



## AUTHORIZATION FOR MEDICATION

NAME OF STUDENT \_\_\_\_\_ SCHOOL \_\_\_\_\_

### TREATMENT PLAN (to be completed by physician)

DATE \_\_\_\_\_ PHYSICIAN \_\_\_\_\_

DIAGNOSIS \_\_\_\_\_ ADDRESS \_\_\_\_\_

MEDICATION & DOSAGE \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

SIDE EFFECTS \_\_\_\_\_ ALLERGIES \_\_\_\_\_

PURPOSE OF MEDICATION \_\_\_\_\_

DIRECTION FOR ADMINISTRATION BY SCHOOL PERSONNEL \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NOTE:** If the medication is to be administered for an extended period of time, see paragraph F on the reverse side.

\_\_\_\_\_  
Signature of Physician

### PARENTAL PERMISSION (to be completed by parent or guardian)

DATE \_\_\_\_\_

My permission is hereby granted to the School Principal or his/her specified delegated personnel to administer prescribed medication to my \_\_\_\_\_

Relationship

\_\_\_\_\_  
Name of Student

**NOTE:** If the medication is to be administered for an extended period of time, see paragraph F on the reverse side.

\_\_\_\_\_  
Signature of Parent or Guardian