

**PHYSICIAN AUTHORIZATION FOR  
MEDICATIONS TO BE TAKEN  
DURING SCHOOL HOURS  
School Year 2019-20**

School \_\_\_\_\_ Fax # \_\_\_\_\_

The following section is to be completed by the PARENT:

Child's Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_

Sex \_\_\_\_\_ Birthdate \_\_\_\_\_ Physician's Name \_\_\_\_\_

Physician's Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

**I am requesting that, during school hours, the school nurse or designated person administer this prescription medication ordered by authorized persons below. I give permission to the school nurse to destroy any medication remaining at the end of the school year, if I do not pick it up.**

Date: \_\_\_\_\_ Parent Signature \_\_\_\_\_

Home Phone \_\_\_\_\_ Emergency Phone \_\_\_\_\_

**THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PHYSICIAN:**

Reason for Medication \_\_\_\_\_

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

Form of Medication \_\_\_\_\_ Tablet/Capsule \_\_\_\_\_ Liquid \_\_\_\_\_ Inhaler \_\_\_\_\_ Injection \_\_\_\_\_

Other (explain) \_\_\_\_\_

Instructions (Schedule and dose to be given at school) \_\_\_\_\_

Start (Date form received) \_\_\_\_\_ Other Date \_\_\_\_\_

Stop \_\_\_\_\_ July 30, 2020 \_\_\_\_\_ Other Date \_\_\_\_\_

\_\_\_\_\_ For episodic/emergency events only

Restrictions and/or important side effects: None expected \_\_\_\_\_

Yes, (Describe) \_\_\_\_\_

Special Storage Requirements \_\_\_\_\_ None \_\_\_\_\_ Refrigerate \_\_\_\_\_ Other (explain) \_\_\_\_\_

Please indicate if you have provided additional information \_\_\_\_\_ on reverse side \_\_\_\_\_ attachment

Date \_\_\_\_\_ PHYSICIAN'S SIGNATURE \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_