Parent and Physician’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, ____________________________________, receive the medications as prescribed below by our physicians.

Date of Birth ____________________

Signature (Parent or Guardian) __________________________________________

Telephone: Home ________________________    Work ______________________

Cell __________________

B. To be completed by physician/licensed prescriber:

I request that my patient, as listed below, receive the following medication -- prescription and non-prescription (i.e.: Inhaler, EpiPen, Insulin):

<table>
<thead>
<tr>
<th>Name of Student</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

Physician Initial/Date:
(Use blank lines for any medication, prescription or over-the-counter, not listed

<table>
<thead>
<tr>
<th>Ibuprofen 200 mg 1-2 tablets every 4-6 hours prn for pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>ES Tylenol 500 mg 1-2 tablets every 4-6 hours prn for pain</td>
</tr>
<tr>
<td>Benadryl 25 mg 1-2 mg 3 times per day prn for allergic reaction</td>
</tr>
<tr>
<td>Pepto-Bismol 262 mg 1-2 tablets prn for abdominal distress</td>
</tr>
<tr>
<td>Dramamine 50 mg 1-2 tablets every 4-6 hours prn for motion sickness</td>
</tr>
</tbody>
</table>

Use back of form to write additional medications

My patient has the following known drug allergies (please list):
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Are all immunizations for this student current according to CDC recommended vaccination schedule?

_____ Yes _____ No  If no, please explain__________________________________________
________________________________________________________________________
*PLEASE CHECK*

☐ I deem this child to be **self-directed** and understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips.

Physician/Licensed prescriber
(print) ________________________________

Physician/Licensed prescriber
(signature) ________________________________ Date __________

Address: ________________________________ Phone: __________

**Prescription medication must be in the original pharmacy labeled container with specific orders and name of medication. Non-prescription medication must be in original packaging.**

**Medication/Refills must be brought to the program by parent/guardian/responsible adult.**