Parent(s)/Guardian Medication Authorization Form

Prescription Medication

Student's Name_____ Birthdate: _____ Grade: _____

Diagnosis: _____

Daily Medication

Medication Name	Dosage: mg, cc, ml, etc.	Route: How it is be given	Frequency: How often	Start Date	Stop Date	Side Effects

As Needed or PRN Medication

Medication Name	Dosage: mg, cc, ml, etc.	Route: How it is be given	Frequency: How often	Start Date	Stop Date	Side Effects

Medical Provider Consent

I authorize the school to give the above medication(s) to this student.

Asthma Inhalers and Epi-Pens Only: The student and his/her parents have been instructed in self-administration and the student may carry an inhaler or Epi-Pen and self-administer at school. Yes _____ No _____

Print Medical Provider Name: _____ Phone: _____

Medical Provider Signature: _____ Date: _____

Parent Consent

I give the school permission to administer the above medication(s) as directed by the medical provider.

Inhaler/Epi-Pen Only: My child may _____ or may not _____ carry and self-administer.

Parent/Guardian Signature: _____ Date: _____

As part of the authorization form, school personnel may contact the medical provider and parent with questions regarding the medication administration including clarification regarding dosage, side effects, or indication of the medication(s) listed above.