SCHOOL MEDICATION PHYSICIAN ORDER
PARENT AUTHORIZATION FORM

NAME ______________________________ BIRTHDATE ______________

SCHOOL ______________________________ GRADE ______________

PHYSICIANS ORDER

I hereby request and authorize you to give:

	Medication	Dosage	Time	Duration
1.				
2.				

Diagnosis for medication: ______________________________ ICD-10 Code______________

Other medication this student is taking:____

Any other recommendations or UNUSUAL side effects: ____

Physicians Signature ______________________________ Today's Date ______________

Physicians Name (Printed) ______________________________ Phone Number ______________

Clinic Name & Address ______________________________ Fax Number ______________

PARENT OR GUARDIAN AUTHORIZATION

1. I request that the above medication be given during school hours as ordered by this student's physician.
2. I release school personnel from any liability in relation to this request when the medication is given as ordered.
3. We will notify the school of any change in the medication (dosage change or if the medication is discontinued before the stated time in the Dr.'s order.)
4. I give permission for the school nurse to communicate with my child's teachers about the action and side effects of this medication.
5. I give permission for the school nurse to consult with the above named physician regarding any questions that may arise with regard to the listed medication or medical condition being treated by this medication.
6. In the event of a field trip, I give permission for the assigned teacher/responsible adult to give the above medication/medications, following school procedure.

Signature of parent or guardian ______________________________ Date ______________

Relationship to student ______________ Phone Number ______________ E-mail address ______________