PARENT AND PRESCRIBER'S AUTHORIZATION FORM

ADMINISTRATION OF MEDICATION IN SCHOOL - YKLI

A. Parent must complete this section:

I request that my child _____ DOB: _____ in grade____ receive the medication(s) as ordered below by our health care provider.

I understand that I must provide the nurse with the medication(s) in the original pharmacy container or in the original over-the-counter medication container.

Signature of Parent:_____ Date:_____

Parent Contact Phone #:_____

B. Licensed health care provider must complete this section:

I request that my patient, as listed below, receive the following medication:

Name of Student: _____Date of Birth:_____

MEDICATION NAME	DOSAGE (mg)	ROUTE	FREQUENCY	PRN

Related Diagnosis or ALLERGY:_____

Possible Side Effects:_____

Other Recommendations:_____

Duration of Treatment:_____

Name of Licensed Prescriber and Title (please print): _____

Prescriber's Signature: _____ Date: _____

Telephone: _____ Fax: _____ **Stamp**: