

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:**