MEDICATION AUTHORIZATION

RETURN COMPLETED FORM TO SCHOOL
WITH GUARDIAN AND HEALTH CARE PROVIDER SIGNATURES

Student's Name: _____ **Date of Birth:** _____

School: _____ **Grade:** _____ **Room/Teacher:** _____

PARENT/GUARDIAN AUTHORIZATION:

HEALTH CARE PROVIDER AUTHORIZATION:

Name of Medication or Treatment	**Reason**	**Dosage**	**Route**	**Time**	**Refrigerate?** (Y/N)	**Self-Administer?**	**Self-Carry?** (Y/N)
					No Yes	No Yes, supervised Yes, unsupervised	No Yes
					No Yes	No Yes, supervised Yes, unsupervised	No Yes
					No Yes	No Yes, supervised Yes, unsupervised	No Yes
					No Yes	No Yes, supervised Yes, unsupervised	No Yes

Diagnosis/Significant Findings: _____

Allergies (Medication and other substances): _____

Health Care Provider signature: _____ Date: _____

This request is valid for a maximum of <u>one</u> year.