**MEDICATION/TREATMENT AUTHORIZATION FORM**

Student's Name_____ Sex_____

Date of Birth_____ Grade_____ School Name_____

**The following section is to be completed by the parent or legal guardian:**

I hereby grant permission to the principal or his/her designee of _____School to assist in the self-administration of the prescribed or over-the-counter medication and/or treatment to my child while in school and away from school while participating in official school activities. **It is my responsibility to notify the school if and when these orders change**.

Parent/Guardian name: _____ Relationship:_____

Emergency Phone #: _____ Home Phone #: _____ Business Phone #:_____

Address: _____

Signature: _____ Date:_____

Over the Counter Medication Authorized:_____

Instructions to Assist with the Self-Administration by the Student of the Medication:_____

List child's allergies**:** _____

**The following section is to be completed by the prescribing physician for prescription medication:**
*(A separate form must be completed for each medication or treatment prescribed)*

The student named in this document is under my medical supervision for the diagnosis described below. I have prescribed the following medication/treatment, which is necessary to be given in school. I am aware that trained non-medical staff may administer this physician prescribed service.

| |
|---|
| **This order is to be effective for the school year: 202____ - 202____ or earlier stop date: _____**<br><br>**Diagnosis** *(for this medication/treatment)***:** |
| **Treatment:** |
| **Name of Medication:** Brand: _____Generic:_____ **Strength**(*i.e. mg/tab*): _____ |

**Instructions to Assist in the Self-Administration of the Medication by the Student**:

_____

**Amount** *(i.e.# of tablets or teaspoons)***:** _____**Time***(s)***:**_____

**Frequency** *(i.e: 6 hrs )***:** _____**Duration** *(i.e: 10 days)***:**_____

**Route:** Oral ___Topical ____Subcutaneous ____I.M. ____Inhaled____ Other *(describe):*_____

**Time medication is given at home** *(if applicable)***:** _____

**Possible side effects:** _____

**Is student authorized to carry and use asthma inhalation medication or EpiPen?** _____

(The Authorization for Possession or Self-Administration of Asthma, Severe Allergy, or Anaphylaxis Medication must be completed entirely by the parents and the physician for a student to be allowed to possess and/or self-administer asthma or severe allergy medication or an Epi-Pen.)

**Has student been instructed in the use of asthma inhaler or EpiPen? Yes No**

**Other Information:**

Physician Signature: _____ Date: _____

Physician Name: _____

Office Address: _____Phone:_____ Fax:_____