Physician Medication Authorization Form

Student Name___________________________ DOB: ________________

Prescription Medication

Date of order: ___________ Discontinuation Date: ___________

Diagnosis*__________________________

Any other medical conditions*___________________________

Name of Medication: ___________________________ Dosage: ____________________

Frequency/ Time: __________________ Route of Administration: __________________

(Please Note: Whenever possible, medication should be scheduled at times other than school hours.)

Side effects, contraindications, possible adverse reactions: ___________________________

Other medications taken by student: ____

Consent for self administration (provided school nurse determines it is safe and appropriate)

Yes ______________ No _________________

Name of Licensed Prescriber; _________________________ Date: __________________

Signature: ____

Telephone Number: _________________________Fax: __________________________

Non-Prescription Medication

Acetaminophen/ Tylenol Dosage_______ Frequency ________ Route of Administration________

Ibuprofen/ Motrin/ Advil Dosage_______ Frequency ________ Route of Administration_______

Robitussin: Dosage _______Frequency _______ Route of Administration_______

Other: __________ Dosage _______ Frequency ________ Route of Administration_______

Name of Licensed Prescriber: ____________________________ Date: _________________

Signature: ____

Telephone Number: ________________________Fax: ____________________________

* If not in violation of confidentiality.