Physician's Authorization of Medication
(Needed for prescription medication only)
2025-26

Full name of child to be medicated: _____

DOB: _____ GRADE _____

This is to certify that, in order to keep this child in optimum health and/or help maintain optimum performance at school, it is necessary that medication be given during school hours.

Name of medication (include trade name): _____

Medication is to be given in form circled: tablet ointment liquid capsule inhalation injection

Other: _____

Dosage amount to be administered during school hours: _____

Hour(s)/Day(s) medication to be administered: _____

Reason for medication: _____

Physician prescribing medication (print): _____

Physician phone number: _____

If this medication is on a PRN (as needed) schedule, please describe how the person administering medication is to determine when medication is needed: _____

_____

Side effects (expected/predictable): _____

The child's parent/guardian knows of this request and is in full agreement that this medication will be administered as indicated. Should the student manifest any of the following symptoms caused by the medication, please discontinue administration and notify the parent/guardian or my office immediately:

_____

_____

Contraindications for administration of medication: _____

_____

Physician's Name: _____PHONE: _____
(PLEASE PRINT)

Physician's Signature (No Stamp)_____ DATE:_____