frogstreet

Medication Authorization Form

To be completed by child's parent(s)/guardian(s). A new form must be completed every year.

Child's Name:_____ Birth Date: _____

Address: _____

Home Phone: _____ Emergency Phone: _____

Facility: _____ Caregiver: _____

All medications to be administered at school require a request from a licensed health professional.
To be completed by child's physician, physician assistant, or advanced practice RN:

Physician's printed name: _____

Office Address:_____

Office Phone:_____ Emergency Phone: _____

Medication Name: _____

Purpose: _____

Dosage: _____ Frequency: _____

Time medication is to be administered and under what circumstances:

_____

Prescription Date: _____ Order Date: _____ Discontinued Date:_____

Diagnosis requiring medication: _____

Expected side effects, if any:_____

Other medications child is receiving, if any: _____

Physician's signature: _____ Date: _____

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize _____ and its employees and agents, in my behalf, to administer or to attempt to administer to my child, lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices, and I agree to indemnify and hold harmless _____ and its employees and agents against any claims.

_____ _____

Parent/Guardian printed name Parent/Guardian printed name

_____ _____

Parent/Guardian signature Date Parent/Guardian signature Date

Medication must be in a properly labeled container from the dispensing pharmacy.