Uncommon Schools | NORTH ★ STAR

**PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL**

***Authorization for Administration of Medication***

A. To be completed by the parent or guardian:

I request that my child _____ grade _____ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication or an adult will supervise my child taking his/her own medication.

Signature (Parent or Guardian): _____

Address: _____

Telephone: Home _____ Work _____ Date: _____

B. To be completed by the licensed health care prescriber:

I request that my patient, as listed below, receive the following medication:

Name of student:_____ Date of Birth:_____

Diagnosis: _____

Name of Medication:_____

Prescribed Dosage, Frequency and Route of Administration: _____

_____

Time to be Taken During School Hours:_____

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____

Other Recommendation:_____

Name of Licensed Prescriber and Title (please print): _____

Prescriber's
Signature: _____ Date: _____

Address: _____ Phone: _____