MEDICATION AUTHORIZATION FORM

This form must be filled out for *every* prescription medication brought or sent to school. Each time there is a change in dose or time, a new authorization form MUST be filled out completely.

****<u>Do not fill out</u> if you are not bringing in medication****

<table>
<tr><td colspan="3">Child's Name:</td><td>Sex:</td><td>Date of Birth:</td></tr>
<tr><td colspan="3">Street Address:</td><td>Zip Code:</td><td>Phone:</td></tr>
<tr><td colspan="4">Physician's Name:</td><td>Phone:</td></tr>
<tr><td colspan="5">Diagnosis for which medication is given</td></tr>
<tr><td colspan="5">Name of Medication:</td></tr>
<tr><td>Medicine to be given</td><td colspan="4">☐ Only as needed ☐ Daily (school year) ☐ Daily (temporarily)</td></tr>
<tr><td colspan="2">Dose:</td><td colspan="3">Time/s:</td></tr>
<tr><td colspan="2">Start Date:</td><td colspan="3">End Date:</td></tr>
<tr><td colspan="4">*For "inhalers" only
If yes, include a copy of the prescription or the original box containing the inhaler with the prescription.</td><td>Current Prescription
☐ YES ☐ NO</td></tr>
<tr><td colspan="5">I give permission for exchange of verbal and written communication between the physician and the school nurse regarding my child's medicine regimen. I give permission for authorized school personnel to administer the above medication to my child.</td></tr>
<tr><td colspan="3">Parent/Guardian Signature:</td><td colspan="2">Date:</td></tr>
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Chadick School District