PARENT AND PRESCRIBER'S AUTHORIZATION FORM

ADMINISTRATION OF MEDICATION IN SCHOOL - YKLI

A. <u>Parent must complete this section:</u>

I request that my child ___________________________ DOB: _________ in grade____ receive the medication(s) as ordered below by our health care provider.

I understand that I must provide the nurse with the medication(s) in the original pharmacy container <u>or</u> in the original over-the-counter medication container.

Signature of Parent:________________________________ Date:_____________

Parent Contact Phone #:_____________________

B. <u>Licensed health care provider must complete this section:</u>

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

Name of Student: ____Date of Birth:_____________

MEDICATION NAME	DOSAGE (mg)	ROUTE	FREQUENCY	PRN

Related Diagnosis or ALLERGY:____

Possible Side Effects:____

Other Recommendations:____

Duration of Treatment:_______________________________________

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

Prescriber's Signature: _____________________________________ Date: _____________

Telephone: _____________________ Fax: ____________________ **Stamp**: