MEDICATION AUTHORIZATION

RETURN COMPLETED FORM TO SCHOOL
WITH GUARDIAN AND HEALTH CARE PROVIDER SIGNATURES

Student's Name: ______________________________ **Date of Birth:** ______________

School: ______________________ **Grade:** __________ **Room/Teacher:** ________________

PARENT/GUARDIAN AUTHORIZATION:

HEALTH CARE PROVIDER AUTHORIZATION:

Name of Medication or Treatment	Reason	Dosage	Route	Time	Refrigerate? (Y/N)	Self-Administer?	Self-Carry? (Y/N)
					No Yes	No Yes, supervised Yes, unsupervised	No Yes
					No Yes	No Yes, supervised Yes, unsupervised	No Yes
					No Yes	No Yes, supervised Yes, unsupervised	No Yes
					No Yes	No Yes, supervised Yes, unsupervised	No Yes

Diagnosis/Significant Findings: ____

Allergies (Medication and other substances): ____________________________________

Health Care Provider signature: ______________________________ Date: ____________

This request is valid for a maximum of one year.

05/13