

Medical Authorization to Administer Medication or Dietary Supplement to Student and Authorization for Release of Health Information

Health Care Provider Order for School to Administer Medication (prescribed) or Dietary Supplement.

I request the following student be given medication at school because I believe there exists a valid health reason which necessitates medication administration during the school day.

Medication #1 Condition being treated		Time to be administered at school Dosage and mode of administration.			
			Side Effect to be expected, if any.	(What emergency measures s	should be taken if this occurs?)
			Medication#2		Time to be administered at school
Condition being treated		Dosage and mode of administration.			
Side Effect to be expected, if any.	(What emergency measures s	should be taken if this occurs?)			
Other medications the School sho	ould be aware of.				
Health Care Provider Name (Printed)		Health Care Provider Signature			
Address		 Date			
Telephone	Fax	Email			
		questions regarding the above medication and possible sider mation between both Health Care professionals.			
Parent Signature and Printed Name					