



*Physician to
Complete
and
Sign

**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.

This Order Good for School Year: _____

Student Name Birthdate

Medication #1 Time to be administered at school

Condition being treated Dosage and mode of administration.

Side Effect to be expected, if any. (What emergency measures 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 should be taken if this occurs?)

Other medications the School should be aware of.

* _____
Health Care Provider Name (Printed)

* _____
Health Care Provider Signature

Address Date

Telephone Fax Email

Parent agrees that the school nurse may contact physician with questions regarding the above medication and possible side effects as needed and the exchange of medically necessary information between both Health Care professionals.

Parent Signature and Printed Name Date

School Nurse | | Phone No. | | Fax No. | |

School Nurse Signature Date