Rochelle Park School District

Midland School #1

Medication Authorization Form

For Daily and "As Needed" Medications

USE ONE FORM FOR EACH MEDICATION

PARENT(S)/GUARDIAN(S) to complete this section:

Student's Full Name _____ School Year _____ Grade _____DOB _____

Physician's Name/Address/Phone _____

I understand that I must supply the school with the equipment/supplies needed to administer the medication for my child. I understand that all medications must be labeled with the name of the medication, name of the student, name of the physician, phone number of the physician, date, and directions for administration. Prescription medication must be labeled by a registered pharmacist.

I request the medication listed below be administered to my child as ordered by the physician. The physician may be phoned with any questions about this medication. 911 will be called immediately in an emergency.

Signature of Parent/Guardian _____ Date _____ Day Phone # _____

PHYSICIAN to complete this section:

Name of medication: _____ Strength of medication _____

Diagnosis for medication: _____ Dose _____ Form _____

What time of day to administer? _____ How soon can it be repeated? _____

If medicine is to be given "As Needed", describe indications: _____

_____

List any significant side effects: _____

Length of time this treatment is recommended: _____

Physician's Stamp:

Physician's Signature _____

Date_____