MEDICATION AUTHORIZATION
REQUIRED ANNUALLY
Independent School District #192

School Year_____

NAME_____ GRADE_____
Last First Middle

DATE OF BIRTH_____

Medication _____ Dosage: _____

Diagnosis/Medical reason for medication _____ICD 10 Code_____

Effective Date: _____ Method of Administration_____Time to given in school_____

Possible side effects _____

What action or treatment should be given if an adverse reaction occurs? _____

_____

Print Physicians Name _____***Clinic Name;*** _____

Physician's Signature _____*Telephone Number:* _____

Fax Number: _____

PARENT/GUARDIAN AUTHORIZATION (Required ANNUALLY)

1. I request that the above medication to be given during school hours as ordered by this student's physician.
2. I will notify the school of any changes in the medication, i.e. dosage change, medication is discontinued.
3. I give permission for the school nurse to communicate with teachers about the dosage, action and side effects of the prescribed medication.
4. **I understand that I must bring the medication to school in a <u>properly labeled bottle</u> and will pick up any unused medication at the end of the school year or it will be disposed of on the last day of school.**
5. I give permission for the school nurse to consult with the above named student's physician regarding any questions that arises with regard to the listed medication or medical condition being treated by this medication.

Signature of parent/guardian _____**Date** _____

Relationship to student _____Phone _____