The Washington New Church School

Medication Prescriber/Parent Authorization Form

Student Name: _____ Birthdate: _____ Teacher: _____ Grade: _____ School Year: _____

To be completed by physician/licensed prescriber:

Medication Name	Dose	Time to be given	Form/Route*	Side Effects	Adverse Reactions

*Routes – oral (pill/capsule/chewable, liquid) – inhaled (inhaler, nebulizer) – topical skin application – topical (eye drop, ointment) – topical ear drop – injection – other (list)

List minimal frequency between doses (especially if "as needed" (p.r.n.)): _____

If "as needed" (p.r.n.), list symptoms/conditions under which medication is to be given: _____

Reason for medication (optional): Medication _____

Special Instructions: _____

Start date if not beginning of the school year: _____ **Stop date** if not end of school year: _____

_____ _____ _____

Physician's signature | Date | Physician's printed name

Physician's Phone #: _____ Fax #: _____ Address: _____

_____

To be completed by parent/guardian:

I request and give permission for (name of child) _____ to receive the above medication(s)/treatment at school according to the standard school policy and for the physicians(s)/staff and school staff to share information needed to assist my child with medication needs (schools require parent/guardian to bring medication in its original container).

_____ _____

Parent/guardian signature | Date

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