

John Rex Charter Elementary School

Authorization for the Administration of Medication

Authorization and Request for the Administration of Medication at school to be used when a physician orders:

- A. Prescription Medication that is to be given for longer than a 10(ten) day period.
- B. Medication that is to be given only when needed.
- C. Non-prescription or "over-the-counter" medication.

Student: _____ Birthdate: _____

Phone: _____ Teacher/Classroom: _____ Grade: _____

School: _____ Phone: _____ Fax: _____

Date form received by the school: _____

• **TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER:**

1. Reason for medication: _____

2. Name of medication: _____

3. Dosage/amount to be given: _____

4. Specific time to be administered: _____

5. Duration (week, month, indefinite, etc.) _____

6. Anticipated reaction to medication (symptoms, side effects, etc.) _____

7. Form of medication/treatment: _____

Tablet _____ Liquid _____ Inhaler _____ Injection _____ Nebulizer _____ Other _____

8. Special storage requirements:

None _____ Refrigerate _____

Physician's Name Physician's Signature Date

Address Phone Fax

• **TO BE COMPLETED BY THE PARENT/GUARDIAN:**

I hereby request and give my permission for the above named school to administer the medication prescribed on this form to my child. If the medication is prescribed by a physician, the pharmacy label must be attached to the medication. If this medication is an "over the counter medication" it must be brought in the original container/box. I further understand that I will be responsible for picking up any medication at the end of the school year. Any medication left at school after June 12 will be discarded utilizing proper procedure.

Parent/Guardian Signature Date