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

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- **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