Cole R-1 School District

Physician Authorization for Medication

Save Print

Student Name _____ DOB _____ Grade _____

Parent / Guardian Name _____

Cell Phone _____ Work Phone _____

Prescriber's Name _____

Prescriber's Phone _____ Prescriber's Fax _____

☐ I give permission for exchange of verbal and written communication between the physician and the school nurse regarding my child's medication regime.

Parent / Guardian Signature _____ Date _____

TO BE COMPLETED BY LICENSED PRESCRIBER

I have determined that it is necessary for this medication to be administered during school hours.

Medicaton to be administered _____

Diagnosis/Reason for medication to be administered:

Route: _____ Dosage: _____ Frequency/time(s) of administration: _____

Potential side effects: _____

Is the student authorized to carry and self-administer this medication at school? ☐ Yes ☐ No

Other specific directions or information regarding this medication/administration:

_____
Signature of Licensed Prescriber

_____
Date