

SCHOOL MEDICATION AUTHORIZATION FORM / IHSP

Name of child: _____ Date of birth: _____

School _____ Phone: _____ FAX#: _____

PHYSICIAN'S ORDER *(To be completed by physician only)*

Name of medication / strength: _____

Dosage: _____ How Often? _____

Time to be given at school: _____ Dose Form _____
(Tablet/Liquid)

Reason for medication: _____

Possible side effects: _____

Student has been instructed by physician in the use of Inhaler and may carry medication with them.

Student has been instructed by physician in the use of the EPI-PEN and may carry medication with them.

Comments: _____

The pupil for whom this medication is prescribed is under my care.

Print Name of Licensed Physician

Signature of Licensed Physician

Address

Phone

Date

TO BE COMPLETED BY PARENT BEFORE GIVING FORM TO DOCTOR

I request that my child, _____, be assisted in taking the above prescribed medication at school by authorized persons. I will comply with the school's policies and procedures. I agree to, and do hereby hold the District and its employees harmless from any and all claims, demands, causes of action, liability or loss of any sort because of, or arising out of, the acts or omissions of the District or its employees with respect to this medication.

I authorize exchange of information between my child's Physician, District Nurse, Teacher(s) and Principal.

Parent Signature

Date

Phone (home)

Address

Phone (emergency)

Name of medication to be given at school _____ **Time to be given at school** _____