Hurley School District

PRESCRIPTION

MEDICATION AUTHORIZATION FORM

Student Name: _____ **DOB:** _____

Parent/Guardian: _____

Home Phone: _____ **Work:** _____ **Cell:**_____

Health Care Provider: _____ **Phone:** _____

Pharmacy: _____ **Phone:** _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED HEALTH CARE PROVIDER

Medication Name:_____
Dosage: _____ **Time Given:** _____
Reason for Medication: _____
Effective Date: _____ **To:** _____

FOR INHALER OR INSULIN:
This student is both capable and responsible for self-administering this medication:
☐ **Yes, Supervised** ☐ **Yes, Unsupervised** ☐ **No**

If Inhaler, please check one:
☐ **Inhaler kept with Student** ☐ **Inhaler kept in Office**

Additional Comments:

_____
_____
_____
_____

A Physician's written order and signature is required for school staff to administer any medication.

Physicians Signature : _____ **Date:** _____

Clinic: _____ **Phone:** _____

I hereby give permission to school employees designated by school officials to give medication to my child according to the doctor's prescription.

I further give permission to school authorities to contact my child's physician/pharmacy regarding this medication.

Parent Signature: _____ **Date:** _____