PICKAWAY-ROSS
CAREER & TECHNOLOGY CENTER
MEDICATION AUTHORIZATION FORM

Student's Name_____Program_____

Student's Address_____

Mother's Name_____ Phone: Work_____ Home_____

Father's Name_____ Phone: Work_____ Home_____

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Name of Medication_____Dosage_____

Time_____ Route of Administration_____

Reason for Medication_____

Special Instructions(storage, sterile conditions,etc.)_____

_____

Adverse Reactions/Side Effects to be reported by physician

_____

Start Date_____Stop Date_____

Physician's Name_____Address_____

Physician's Signature_____Telephone_____

PARENT'S REQUEST FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I do hereby request and authorize school personnel to administer the medication described on the above form in accordance with the procedures prescribed hereon and agree to (1) deliver the medication to the school on a timely basis, (2) notify the school if there is a change in the physician, (3) notify the school if the medication, the dosage, or the procedure is changed or to be eliminated.

Parent's Signature_____Telephone_____

Medication must be received in the container in which it was dispensed by the prescribing physician or others licensed to prescribe medication.