Pickaway-Ross Career & Technology Center Medication Authorization Form

Student's Name_____Program_____

Student's Address_____

Mother's Name_____

Mother's Phone: Home_____Mobile_____Work_____

Father's Name_____

Father's Phone: Home_____Mobile_____Work_____

Physician's Request for Administration of Medication by School Personnel

Name of Medication_____Dosage_____

Time_____Route of Administration_____

Reason form Medication_____

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

_____

Adverse Reactions/Side Effects to be reported by physican_____

_____

Start Date_____Stop Date_____

Physician's Name_____

Physician's Address_____

Physician's Signature_____Phone_____

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_____Date_____

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