

## **MEDICATION AUTHORIZATION**

RETURN COMPLETED FORM TO SCHOOL
WITH GUARDIAN AND HEALTH CARE PROVIDER SIGNATURES

hool: ARENT/GUARDIAN AL		Grade		ъ.	/=		
ARENT/GUARDIAN AU			Grade:F		Room/Teacher:		
	UTHORIZAT	ION:					
EALTH CARE PROVID	DER AUTHO	RIZATION:					
	DER AUTHO	RIZATION:					Self-
EALTH CARE PROVID  me of Medication or  Treatment	DER AUTHO Reason	PRIZATION:  Dosage	Route	Time	Refrigerate? (Y/N)	Self-Administer?	Self- Carry? (Y/N)
me of Medication or			Route	Time	Refrigerate? (Y/N) No Yes	No Yes, supervised	Carry?
me of Medication or			Route	Time	(Y/N) No	No Yes, supervised Yes, unsupervised No	Carry? (Y/N) No Yes
me of Medication or			Route	Time	(Y/N) No Yes	No Yes, supervised Yes, unsupervised	Carry? (Y/N) No
me of Medication or			Route	Time	(Y/N) No Yes No	No Yes, supervised Yes, unsupervised No Yes, supervised	Carry? (Y/N) No Yes

This request is valid for a maximum of one year.

Allergies (Medication and other substances):

Health Care Provider signature: \_\_\_\_\_ Date: \_\_\_\_\_