



Physician/Parent Authorization Form for Prescription Medication Treatment

Student's Name: _____ Age: _____ YOG: _____

PART I: TO BE COMPLETED BY A PHYSICIAN:

Date of order: _____
Diagnosis: _____
Medication: _____ Dose: _____
Treatment: _____
Time of administration at school: _____ Route: _____
Duration of administration: _____
Possible side effects: _____
Reason for medication: _____
If PRN for what symptoms? _____

(For inhaler and epi-pen medication only:)

___ It has been determined that this student is able to self-administer and carry inhalant medication or Epi-pen and has been trained in its use including knowing when the medication is to be used.

___ This student should not self-administer inhalant medication or Epi-pen.
Student has demonstrated ability to self administer.

Physician Signature Printed Name Date

Physician Office Phone Number and Fax Number

PART II TO BE COMPLETED BY PARENT/GUARDIAN:

I assure that the first dose of this medication has been given without adverse effects and request that Catholic High nurse or her designee, administer the above medication, as prescribed by our physician, to my child, _____.

* The exception to first dose of medication being given at home would be the use of Epi-pens only!*

Parent/Guardian Signature and Date