



**MEDICAL PROVIDER AUTHORIZATION FORM
PRESCRIPTION MEDICATION**

Student's Name:	DOB:
School:	Grade:
Diagnosis:	

DAILY MEDICATION

Medication:	Dosage:	Route:	Frequency:	Start Date:	Stop Date:	Side Effects:
1.						
2.						

AS NEEDED OR PRN MEDICATION

Medication:	Dosage:	Route:	Frequency:	Start Date:	Stop Date:	Side Effects:
1.						
2.						

MEDICAL PROVIDER CONSENT

I authorize the school to give the above medication(s) to this student.	
Asthma Inhalers and Epi-Pens Only: This student and his/her parents have been instructed in self-administration and the student may carry an inhaler or Epi-Pen and self administer at school. Yes <input type="checkbox"/> No <input type="checkbox"/>	
Print Medical Provider Name:	Date:
Medical Provider Signature:	

PARENT CONSENT

I give the school permission to administer the above medications as directed by the medical provider. Inhaler/Epi-Pen Only: My child may <input type="checkbox"/> or may not <input type="checkbox"/> carry and self-administer.	
Parent/Guardian Signature:	Date:

As part of the authorization form, school personnel may contact the medical provider and parent with questions regarding the medication administration including clarification regarding dosage, side effects or indication of the medication(s) listed above.