



Parent-Physician Authorization for Medication Administration

Student's Name _____ Date of Birth _____ Allergies _____

<p>Medication _____ Strength _____ Dose _____</p> <p><input type="checkbox"/> Scheduled: every _____ hours OR at scheduled time(s) _____</p> <p><input type="checkbox"/> As needed: every _____ hours OR _____ times a day</p> <p>Start date _____ End date _____ (Valid for current school year only)</p> <p>Reason for medication _____</p> <p>Possible reactions or restrictions _____</p>

NOTE:

- Over-the-counter medications must be furnished by the parent/guardian and given to the school nurse *in the original container*.
- Prescription medications must be in the original container *with the original pharmacy label intact*. If needed, a second container can be obtained from your pharmacist so only the appropriate amount of medication is delivered to school.
- If a medication is a controlled substance or needs to be given at school for more than six weeks, a physician's signature is required.
- A physician's order is required if a student must keep a medication (EpiPen®, inhalers, etc.) with him/her while at school. The medication must be in the original container with the original pharmacy label.

I agree to the above and give permission for the medication listed to be given by Calvary Episcopal Preparatory personnel during school hours.

Parent/Guardian Signature _____ Date _____

THE SECTION BELOW IS TO BE COMPLETED BY A PHYSICIAN (IF REQUIRED).

Instructions/Comments _____

Physician's Signature _____ Date _____

Physician's Printed Name _____ Phone # _____