KALAMAZOO PUBLIC SCHOOLS
MEDICATION PRESCRIBER AND PARENT/GUARDIAN AUTHORIZATION FORM

Student Name:_____Date of birth____/_____/_____School Year_____

I. To be completed by Physician/Licensed Prescriber

	Medication Name/Indications	Dose	Time to be Given/Frequency	Form/Route*	CommonSide Effects/ Adverse Reactions	Start/Stop Dates
1.						
2.						

*Routes : Oral (pill/capsule/chewable,liquid) • Inhaled (inhaler, nebulizer) • Topical skin application • Topical (eye drop, ointment) • Topical ear drop • Injection • Other (list)

List minimal frequency between doses (especially if PRN)_____

If PRN list symptoms, conditions, under which medication is to be given:_____

Special Instructions:_____

_____

_____ _____ _____
Physician's Signature Date Physician's Printed Name

(_____)_____ (_____)_____ _____
Physician's Phone Physician's Fax Physician's Address

II. To be completed by Parent/Guardian: I request and give permission for my child_____to receive the above medication(s) at school according to school district policy. I give consent for the school district staff to share information with the physician and/or the physician's staff as needed to assist my child with medication needs.

_____ _____
Parent/Guardian Signature Date