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/Indication	Dose	Time to Be Given/ Frequency	Form/Route*	Common Side 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 p.r.n.):_____

If p.r.n., list symptoms, conditions under which medication is to be given:_____

Special Instructions: _____

_____

_____ _____ _____

Physician's Signature Date Physician's Printed Name

_____ _____ _____

Physician's Phone Number Physician's Fax Number 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

03/04/03