Prescription Medication Authorization
to be completed by a Physician

Student Name _____Date of Birth _____

_____

Parent's Signature Daytime Phone Date

Prescription Medications: Including, but not limited to Epi-pens and inhalers

Medication_____ Dosage_____

If medication is to be given on an as-needed basis, specify the symptoms/conditions when medication is to be given and the time interval at which it may be given again: _____
_____
_____
_____
_____

Medication_____ Dosage_____

If medication is to be given on an as-needed basis, specify the symptoms/conditions when medication is to be given and the time interval at which it may be given again: _____
_____
_____
_____
_____

Medication_____ Dosage_____

If medication is to be given on an as-needed basis, specify the symptoms/conditions when medication is to be given and the time interval at which it may be given again: _____
_____
_____
_____

Additional information or instructions:_____
_____
_____
_____
_____
_____
_____
_____

Physician's Signature:_____Date:_____