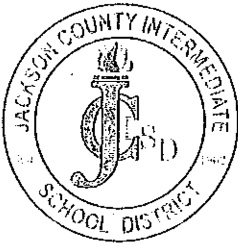

Jackson County Intermediate School District
Lyle Torrant Center

SCHOOL MEDICATION AUTHORIZATION FORM

Please complete and return to school

Part I (To be completed by parent)

Student:____Birthdate:________________________

School:____Classroom:______________________

I hereby request that my child be administered medication at school by school personnel. I understand that the medication will be administered as directed by the physician and medication related information will be exchanged with the physician as necessary. The physician shall notify the school in writing if this medication is to be discontinued. Any changes in dosage or frequency of the medication require resubmission of this form.

Parent/Legal Guardian's Signature:____

Address:____

Telephone: (home)____________________(work)____________________date_____________
(cell phone/pager)_____________________________________

****Medication is to be brought to school by the parent/caregiver and must be in a regulation prescription container labeled with the date, name of the student, name of the physician, name of the medication and dosage.**

Part II (To be completed by physician) (Please Print)

Physician's Name:________________________________Phone:___________________________

Address:____

Medical condition for which medication has been prescribed:______________________________

Prescription: Name of Medication:____

Dosage:__________________________Frequency:___________________________

Time(s) to be given during school hours:___________________________________

Comments regarding medication: (side effects, other directions):___________________________

____

Physician's Signature:____________________________________Date:___________________

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TDD- Hearing Impaired 1-800 356 3232