

Perpich Center for Arts Education

Physician Order and Parent Authorization Administration of Medication

Parents/guardians requesting the School Nurse or authorized designated school staff to give medications to their student during this school year must provide this written Authorization signed by parent/guardian and the student's health care provider.

Student Name _____ Date of Birth _____ Grade _____

TO BE COMPLETED BY PHYSICIAN/LICENSED PRESCRIBER:

Diagnosis	Medication	Dose	Time	Route	Possible Side Effects

Other considerations/directions _____

Start Date _____ Stop Date _____ (Authorizations expire at end of school year)

Print name of Physician/Licensed Prescriber

Signature of Physician/Licensed Prescriber

Date

Clinic Address

Phone

Fax #

PARENT/GUARDIAN AUTHORIZATION

1. I request the above medication(s) be given as ordered by this student's physician/licensed prescriber.
2. I will notify the school of any change in medication(s). Example: dosage change, medication is stopped.
3. I give permission for the School Nurse to communicate, as needed, with school staff about the student's health condition and medication(s).
4. I give permission for the nurse to consult with the student's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) being treated by the medication(s).
5. I give permission for the medication(s) to be given by school personnel as delegated by school nurse.

Parent/Guardian Signature

Date

Daytime Phone