Appendix 1

Health care provider authorization for prescription and over-the-counter medication administration in school

Parents: Have your child's physician complete and sign this form. Return to the school office along with the Parent Consent form.

Name of student	
Date of birth	
Medication	
Dosage	
How to administer	
To be given at the following time(s) or circumstances	
Purpose of medication	
Special instructions	
Side effects to look for	
Restrictions	
If required, has an emergency plan been completed? (circle)	Yes No N/A
Does the student have (circle)	Asthma Severe allergy Seizures Diabetes Other (explain):
Medical professional's signature	
Date	

Health care provider: Please provide your office stamp on this document.