MEDICATION AUTHORIZATION FORM

Colfax School District No. 300

1110 N Morton Street, Colfax WA 99111
(509) 397-3042 FAX (509) 397-2414

Jennings Elementary (509) 397-2181
FAX (509) 397-6741

Colfax High School (509) 397-4368
FAX (509) 397-2414

Student's Name_____ DOB:_____ Grade_____ Date_____

Parent's Home Phone #_____ Work# _____

PHYSICIAN ORDER TO ADMINISTER MEDICATION AS INSTRUCTED TO THE ABOVE STUDENT. THE SCHOOL DOES NOT SUPPLY ANY MEDICATIONS.

Name of Medication:_____

(ONLY 1 MEDICATION PER FORM)

Doseage_____

Route (method of administration) _____

Time/Frequency (If PRN specify length of time between doses)_____

Reason for medication_____

Possible side effects_____

Start Date:_____ **Stop Date:**_____

(ALL AUTHORIZATIONS EXPIRE AT THE END OF THE SCHOOL YEAR)

Physician's Signature_____ Date_____

Physician's Printed Name_____ Phone #_____

PARENTAL PERMISSION: I request this medication to be given to my child as prescribed by the physician above. I understand that my child's medication must be supplied to the school by the parent in an original container that has not passed its expiration date. The medication will be kept in the locked medication cabinet/drawer in the office.

Parent's Signature_____

Parent's Printed Name_____

Field Trip Medication Record

Signature of trained person giving the medication:_____

Date and Time medication was given: