MEDICATION REQUEST AND AUTHORIZATION FORM FOR PRESCRIPTION AND OVER-THE-COUNTER MEDICATION

Edwardsburg Public Schools

Student Name:_____ Date:_____

School:_____ Grade:_____ DOB:_____

Diagnosis/Reason for Medication:_____

Prescription Medication	**Dosage**	**Time**	**Special Instruction**
Over-the-Counter Medication	**Dosage**	**Time**	**Special Instruction**
FDA approved topical substance	***Physician signature not required***		

Physician Comments (please list any probable side effects or restrictions)

_____

_____

For Over-the-Counter Medication Please Check Option 1 or 2 Below:

1. _____self-administer such medication(s) in the presence of an authorized staff member
2. _____keep the medication(s) in his/her possession and self-administer the medication(s) as needed

***Physician Signature:**_____ **Date:**_____
(Required for <u>prescription</u> and <u>over-the-counter</u> medication to be given at school/extra-curricular activities)

Physician's Address and Phone:_____

I have received and understand the Parent Guidelines for Medications at School. I request that my child be given the medications above according to the instructions listed. I agree to notify the school in writing if medication is discontinued and provide a new authorization form if the medication, dosage, schedule, or procedure is changed.

Parent Signature:_____ Date:_____