STUDENTS **TECUMSEH PUBLIC SCHOOLS** **FORM #7.2**

Medication Prescriber/Parent Authorization Form

Student Name: _____ DOB: _____ Teacher: _____ Grade: _____ School Year: _____

To be completed by physician/licensed prescriber:

	Medication Name	Dose	Time to be given	Form/Route*	Side Effects	Adverse Reactions
1						
2						
3						
4						

*Routes ~ oral (pill/capsule/chewable/liquid) ~ inhaled (inhaler/nebulizer) ~ topical skin application ~ topical (eye drop/ointment) ~ topical ear drop ~ injection ~ other (list)

List minimal frequency between doses (especially if p.r.n.): _____

If p.r.n., list symptoms/conditions under which medication is to be given: _____

Reason for medication (optional): Med. 1: _____, Med. 2: _____ Med. 3: _____ Med. 4: _____

Special Instructions: _____

START DATE (if not the beginning of the school year): _____ STOP DATE (if not the end of the school year): _____

_____ _____ _____

Physician's signature Date Physician's printed name

Physician's phone#: _____ Fax #: _____ Address: _____

To be completed by parent/guardian:

I request and give permission for (name of child) _____ to receive the above medication(s)/treatment at school according to standard school district policy and for the physician(s)/staff and school district staff to share information needed to assist my child with medication needs.
(Schools require parent/guardian to bring medication in its original container).

Parent/Guardian signature: _____ Date: _____