Strain-Japan R-16 School District

Phone (573) 627-3243
Fax (888) 971-4401

PHYSICIAN AUTHORIZATION FOR PRESCRIPTION MEDICATIONS

Name of Student_____Date of Birth_____

Address_____Grade_____
Street City/State/Zip

Name of Licensed Prescriber_____Title_____

Doctor's Telephone Number_____

I HAVE DETERMINED THAT IT IS NECESSARY FOR THIS MEDICIATION TO BE ADMINISTERED DURING SCHOOL HOURS.

Medication to be administered _____

Route_____Dosage_____

Frequency/Time(s) of administration at school_____

Other specific directions or information regarding this medication/administration:

_____

Specific side effects, contraindications or possible adverse reactions to be observed:

_____ _____
Signature of Licensed Prescriber **Title** **Date**

Prescription Authorization valid for one year, unless otherwise noted.

PARENTAL AUTHORIZATION I authorize school health personnel to administer the above prescribed medication.	YES	NO
I give permission to the school health personnel to share information relevant to the prescribed medication administration as the health personnel determines appropriate for my son/daughter's health and safety.		
I understand that I may cancel this request at any time, and/or retrieve the medication from the school at any time.		
I understand the medication will be destroyed if it is not picked up within one week of following termination of the order or one week beyond the close of school.		
I understand that an adult will be the one to transport medication to and from school.		
Parent /Guardian Signature: **Date:**		