PMA
DISCOVER YOU.

PARENT/GUARDIAN AUTHORIZATION FOR PRESCRIPTION MEDICATION 2016 - 2017

Please fill out all areas. Form must be completed by the Parent or Guardian.

I request that my daughter/son _____ receive the medication prescribed in the form below by his/her physician _____
Date:_____
Address_____ Telephone #_____
Parent/Guardian Signature:_____

This portion is to be filled out by the PRESCRIBING PHYSICIAN

I request that my patient receive the following medications:

Name of Student_____ Diagnosis_____

Medication_____ Prescribed Dosage_____

Route of Administration_____ Frequency _____ Times _____

Medication_____ Prescribed Dosage_____

Route of Administration_____ Frequency _____Times _____
(Please note: Whenever possible, medication should be scheduled at times other than school hours)

Expected Duration of Treatment: _____

Possible Side Effects, Contraindications and Adverse Reactions_____

Other Recommendations _____

_____

PLEASE PRINT
Physician's Name _____ **Telephone #**_____

Physician's Address_____

Physician's Signature_____ **Date:**_____