6 W X G H Q W ¶ V Name	Date of Birth	Grade

Medication:	Dosage:	Route:
Purpose of Medication:		
Time of day medication will be given at school:	Frequency: (e.g. daily)	Allergies to food, medicines, or other items? ☐NO ☐YES List allergies :
Anticipated number of days medication will be given at school: ☐Until the end of the current school year ☐_____weeks ☐_____days		Is this medication a controlled substance? ☐NO ☐YES
Possible Side Effects:		

Health Care Provider Authorization

3 U H V F U L E L Q J + H D O W K & D U H 3 U R Y L G H U ¶ V 6 L J Q D W X U H (Required If Prescribed Medication)	Date:
, Q V H U W 3 U R Y L G H U ¶ V 1 D P H D Q G $ G G U H V V 6 W D P S % H O R Z	