Phoenix Academy
OF ART & SCIENCE

Prescription Medication Authorization

All medicine must be in the original container

Please complete the information below for Physician Ordered/Authorized and Parent/Legal Guardian Request for Administration of Medication by School Personnel. **This form MUST be completed and signed by a physician for prescription medications.**

Student's Full Name: _____ DOB: _____

I hereby request and authorize you to administer to the above-named student:

Medication	Dosage	Time	Duration	Diagnosis/reason for medication	Possible Side Effects

Other medications taking at home: _____

Medication allergies (if any): _____

_____ Phone: _____
Physician's Name

_____ Date: _____
Physician's Signature

I, the parent/guardian, request this medication be given as prescribed. I release school personnel from any liability in the administration of this medication at school. I understand that I am responsible for communications with the health care providers ordering this medication. I understand that to promote safety of my child, medication information may be shared with school personnel working with my child and with 911 personnel, if they need to be contacted. **I understand that this medication may or may not be administered by a school nurse.**

_____
Parent/Legal Guardian Name

_____ Date: _____
Parent/Legal Guardian Signature