PLEASE ONLY FILL THIS FORM OUT IF NECESSARY

Flat Rock Community Schools
Medication Prescriber/Parent Authorization

Administration of prescribed medication during school hours by school personnel requires a labeled pharmacist bottle with physicians name each time a supply is sent. Non-prescription medication must be sent in original containers.

Student Name _____ Birthdate _____ Age _____

Address _____ Phone _____

School _____ Grade _____ School Year _____

Medication Name	Dose	Time to be Given	Form/Route*	Side Effects	Adverse Reactions

Medication Name	Dose	Time to be Given	Form/Route*	Side Effects	Adverse Reactions

*** 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 PRN): _____

If PRN, list symptoms/conditions under which medication is to be given:

_____

Reason for Medication #1 (optional): _____

Reason for Medication #2 (optional): _____

Special Instructions:

_____

Physician's Signature _____ Date _____ Physician's Printed Name _____

Physician's Address _____ Phone _____ Fax _____

Parent Authorization

I request that school personnel give my child the medication ordered above according to standard school policy.

Parent/Guardian Signature** _____ Date _____

For Parents of Secondary Students Only - Complete Above Information and Sign Below

My son/daughter has my permission to self administer this medication.

High School ☐ No ☐ Yes - Unsupervised***

Simpson ☐ No ☐ Yes - Unsupervised*** (Inhalers and throat lozenges only)

Parent/Guardian Signature _____ Date _____

*Asthma Management Form

**Parent Signature indicates that policy and procedures have been read.

***The student is strictly forbidden from transferring medication to other students.