Bay Area Catholic Schools

Physician Prescribed and Over the Counter Medication Authorization Form

Please circle appropriate Med-form level:

Med-1 Med-2 Med-3 Med-4

Student Name_____ **Birth date**_____ **Teacher/Counselor** _____**Grade**_____ **School Year** _____

To be completed by physician/licensed prescriber:

	Medication (in original container)	Dose	Time to be Given	Form/Route*	Possible Side Effects	Adverse Reactions (Report to Parent)
1						
2						

*Routes-oral, inhaler, topical, injection, other

Special Instructions _____

List symptoms/conditions under which medication ordered as needed (p.r.n.) is to be given: _____

_____

If p.r.n., MINIMUM amount of time between doses: _____

Reason for medication (optional): Medication #1 _____ Medication #2 _____

Special Instructions: _____

Start Date: _____ Stop Date: _____

Physician's Printed Name: _____ Physician's Address _____ Physician's Fax # _____

Physician's Signature _____ Date _____

(Required for over the counter and/or self administered drugs)

To be completed by parent/guardian: I request and give permission for (name of child) _____ to receive the above medications(s) at school according to standard school system policy and for the physician's staff and school personnel to share relevant information regarding my child's medication needs.

Parent/Guardian Signature _____ Date _____