STEPS Educational Group
MEDICATION AUTHORIZATION FORM

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*A separate medication authorization form is required for each prescription and non-prescription medication administered.

Student Name: _____**DOB:**_____

To Be Completed by the Physician/Dentist

Medication Name: _____

Dosage: _____Dosage Time/s: _____

Reason for medication: _____

Start date: _____ Stop date: _____

Special instructions:

_____

Potential adverse reactions to be reported:

_____

Physician / Dentist Signature: _____

Physician / Dentist Phone number: _____ Fax: _____

Parent/Guardian: I give permission for my child to receive this medication at school according to the school district policy and as instructed by my child's physician/dentist.

I agree and am responsible to:
• Deliver my child's medicine to school in its original container • Ensure prescription medication is labeled by a pharmacist or healthcare provider
• Ensure the medication is current within the past 12 months and provide new medication upon expiration
• Administer the first dose of any new medication, except in case of emergency • Tell the school as soon as possible if there is a change in the use of my child's medicine
• Tell the school if my child gets a new healthcare provider
• Have my healthcare provider complete a new medicine form for my child if the medicine or dose changes. I agree for child's healthcare provider to talk with the school or any school staff person about this medicine. No other part of my child's medical health will be discussed

Parent/Guardian Signature: _____

Phone: _____