East Buchanan C-1 School District

Physician Authorization for Medication

Name of Student:_____ Date of Birth:_____

Name of Licensed Prescriber:_____ Title:_____

Business phone number:_____ Emergency number:_____

**I have determined that it is necessary for this medication to be administered during school hours.**

Medication to be administered:_____

Route:_____ Dosage:_____ Frequency/time(s) of administration:_____

Other specific directions or information regarding this medication/administration:

_____

_____

_____

Special side effects, or possible adverse reactions to be observed:_____

_____

_____

Consent for self-administration, provided the school nurse determines it is safe and appropriate.

Yes:_____ No:_____

_____ _____

Signature of licensed prescriber Date