Medication Prescriber/Parent Authorization Form

To authorize the Lycée Rochambeau to administer medication to your child at school, the following is required:

- The medication is furnished by the parent(s) or guardian in a container labeled by the pharmacist or physician with:
  The name of the child, the name of the medication, conditions for proper storage.
  The name of the physician, dosage, route, prescription date and expiration date.

- The child's physician must complete the Physician Order below.

Student Name:_____DOB:__/__/____Grade:___School Year____

To be completed by physician/licensed prescriber:

Medication Name(s)	Dose(s)	Time to be given	Form/Route
1. 2. 3.			

**Routes-oral (pill/capsule/chewable,liquid)-inhaled(inhaler, nebulizer)-topical skin application-topical (eye drop, ointment)-topical ear drop-injection-other(list)*

If P.R.N., list symptoms/conditions under which medication is to be given:
……..…..
Side Effects:……
Adverse Reactions:…….
Special Instructions:……
Reason for medication:……...

Start date: ……**Stop date:**……

FOR INHALER AND EPI-PEN MEDICATION:

- ☐ It has been determined that this student is able to self-administer and carry inhaler medication or Epi-pen and has been trained in its use including knowing when medication is to be used.
- ☐ This student should not self-administer inhaler or Epi–pen

_____ _____ _____
Physician's signature Date Physician's printed name

Physician's phone #:_____ fax#_____ Address:_____

To be completed by parent/guardian:

We…….certify that the first dose of this medication was given without problems and we request that the Lycée Rochambeau personnel administer the medication as prescribed by physician……for the child…….…….

_____ _____
Parent/guardian signature Date