Authorization for PRESCRIPTION Medication – Confidential

Name of student _____ Date of birth _____

Grade _____ Homeroom_____

Medication _____

Time(s) of day medication is to be given _____

Reason for medication _____

Start date of medication _____ End date of medication _____

Special instructions _____

_____

Has the first dose of this medication been given? YES NO

**School personnel are prohibited from giving the first dose of any medication.

- **Whenever possible, medicine should be given at home. It is our policy to limit medication being given during the school day.**
- **The physician's written authorization, including all necessary instructions for administering the medication, must accompany this request.**
- **All medicine needs to be sent in its original container.**
- **If you have any questions, please contact the school nurse at 717-846-8871 x221.**

Printed Name of Prescribing Doctor _____

Signature of Prescribing Doctor _____

Date _____

Printed Name of Parent _____

Signature of Parent _____

Phone Number (M-F 8A-3P) _____Date _____