La Joya ISD. healthservices

Authorization from Physician for Medication Administration

Student Name: ________________________________D.O.B._____________Date:____________________

Medical Condition/or Diagnosis: ____

Prescribing Physician: ____

Name of Medication: ____

Dosage: ____

Times to be given in school: ____

Continue this medication until: ____

Other Instructions: ____

____

MEDICINE MUST BE IN ITS ORIGINAL CONTAINER WITH STUDENT'S NAME

CLEARLY WRITTEN WITH U.S. PHARMACIST'S LABEL

_____________________ __________________ __________________

Physician's Signature Phone Number Date

____________________________________ _____________________________ _____________________

School Phone Fax