GALESBURG-AUGUSTA COMMUNITY SCHOOLS
Medication Prescriber / Parent Authorization Form

Student Name: _____ Birthdate: _____ Teacher: _____ Grade: _____ School Year: _____

	Medication Name	Dose	Time to be given	Form / Route*	Side Effects	Adverse Reactions
1						
2						
3						
4						

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

List minimal frequency between doses (especially if p.r.n.): _____

If p.r.n., list symptoms / conditions under which medication is to be given: _____

Reason for medication (optional): Medication #1 _____ Medication #2 _____
Reason for medication (optional): Medication #3 _____ Medication #4 _____

Special Instructions: _____

Start date if not beginning of the school year: _____ Stop date if not end of the school year: _____

_____ _____ _____
Physician's Signature Date Physician's Printed Name

Physician's Phone #: _____ Fax #: _____ Address: _____
_____

To be completed by parent / guardian:

I request and give permission for (name of child) _____ to receive the above medication(s) / treatment at school according to standard school district policy and for the physician(s) / staff and school district staff to share information needed to assist my child with medication needs. (Schools require parent / guardian to bring medication in it's original container).

_____ _____
Parent / Guardian Signature Date