King Center
Charter School

PARENTS AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL / SCHOOL EVENTS

A. To be completed by the Parent/Guardian:

I request that my child, _____ grade_____ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled container from the pharmacy. I understand the school nurse will administer the medication or an adult will supervise my child taking his/her own medication.

Signature of Parent/Guardian:_____ Date:_____

Address:_____ City_____ State_____ Zip_____

Telephone: Home_____ Work_____

B. To be completed by the licensed health care prescriber:

I request that my patient, as listed below receive the following medication:
Name of student:_____ Date of birth:_____
Diagnosis:_____
Name of medication:_____
Dosage, Frequency and Route:_____
Time to be taken during school hours: _____
Duration of treatment:_____
Possible side effects and adverse reactions (if any) :_____
_____
Other recommendations:_____
_____

Name of Licensed Prescriber and Title:_____
Prescriber's signature:_____ Date:_____
Address:_____ Phone:_____

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