ALBERT LEA AREA SCHOOLS
MEDICATION PHYSICIAN ORDER AND PARENT AUTHORIZATION FORM

NAME_____BIRTHDATE_____
Last First Middle

SCHOOL _____GRADE_____

PHYSICIAN'S ORDER:

I hereby request and authorize you to give the following:

Medication	Dosage	Time	Duration

1. _____
2. _____
3. _____

Diagnosis/medical reason for medication:_____

Other Medications this student is taking: _____

Other Recommendations/UNUSUAL side effects:

Physician's Signature:_____Date:_____

Printed Physician Name:_____Phone:_____

Clinic Name & Address:_____Fax# _____

PARENT/GUARDIAN AUTHORIZATION:

1. I request that the above medication be given during school hours as ordered by this student's physician.
2. I release school personnel from any liability in relation to this request when the medication is given as ordered.
3. We will notify the school of any change in the medication (dosage change; medication is discontinued before the time stated in the physician's order).
4. I give permission for the school nurse to have communication with teachers about the action and side effects of this medication.
5. I give permission for the school nurse to consult with the above-named student's physician regarding any questions that arise with regard to the listed medication or medical condition being treated by this medication.
6. Field Trips- I give permission for the assigned teacher/responsible adult to administer the medication on a field trip, as necessary, following school procedure.

Signature of parent/guardian:_____Date: _____

Relationship to student: _____Daytime Phone #:_____