Medication Authorization Form

To be completed by Child's Physician

PLEASE COMPLETE FULLY AND CAREFULLY

School: ______________________________

Child's Name: ______________________________
(Last) (First)

Medications

Name of Medication:	Purpose of Medication	Dosage Prescribed	Dosage Schedule (routine/as-needed)	Dosage Form (tablet, liquid, etc.)

Precautions, special instructions, possible adverse effect(s), or comments:

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Note: The physician providing the information on this form MUST be licensed to practice medicine in California.

The above named child is under my care:

Fax #: ____________

Physician's Name (print) : Dr.______________________________ Phone #: ____________
(Last) (First)

Office Name and Address: ______________________________

Physician's Signature: ______________________________ **CA License #:**____________

We hereby authorize the school to administer the above listed medications in accordance with the instructions noted.

Parents Signature: ______________________________ **Date**: ____________