Physician's Authorization Form - For Prescription and Non Prescription Medications

Student Name _____ Date of Birth _____

Parent Phone # _____ Grade: _____ Homeroom Teacher _____

In order to help protect your child's health, your consent and written authorization from a licensed healthcare provider are required when it is necessary for your child to receive prescription and non-prescription medications at Mallard Creek STEM Academy. Medications cannot be given to your child at school until this authorization has been received. A separate form is required for each medication. New authorization forms are required every year at the beginning of school, whenever the dose or directions change, or when a new medicine is prescribed. It is your responsibility to provide all medications to be given at school. Each medication must be in the original container from the pharmacy labeled with your child's name. Most pharmacies will provide an extra container for school use upon request. Medication cannot be sent home with your student.

Parent or Guardian's Permission: I give permission for my child to receive this medication during school hours. I understand that it is my responsibility to purchase and supply this medication. On behalf of my child I absolve Mallard Creek STEM Academy and their agents and employees from any and all liability whatsoever that may result from my child taking this medication at school. I give permission for school personnel to contact my child's physician regarding their medication or health condition if necessary. I understand that if the medication is not picked up by the last day of school it will be discarded.

_____

Signature of Parent or Guardian Date Daytime Phone Number

FOR HEALTH PROFESSIONAL USE ONLY: PLEASE WRITE LEGIBLY

Medication prescribed _____ Strength/Dose _____

Time medication is to be administered at school _____

Date medication is to begin _____ End _____

Possible side effects _____

____ **(Check if applicable) THIS MEDICATION IS TO BE USED FOR EMERGENCIES ONLY.**

For Emergency Medications Only

_____ (Check if applicable) Please allow this student to self-administer this medication.

_____ (Check if applicable) This student should carry this medication at all times.

It is necessary for this student to receive this medication during school hours in order to maintain or improve health and to benefit from school attendance.

_____

SIGNATURE OF HEALTH PROVIDER **DATE** **PHONE NUMBER**