KALAMAZOO PUBLIC SCHOOLS MEDICATION PRESCRIBER AND PARENT/GUARDIAN AUTHORIZATION FORM

Student Name:	Date of birth	/	/	School Year
I To be completed by Physician/Licensed Prescriber				

1. To be completed by Physician/Licensed Prescriber

	Medication Name/Indications	Dose	Time to be Given/Frequency	Form/Route*	CommonSide Effects/ Adverse Reactions	Start/Stop Dates
1						
2						

*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 PRN)______

If PRN list symptoms	, conditions,	under which	medication	is to be given:_
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Special

Instructions:_____

Physician's Signatu	re	Date	Physician's Printed Name	
() Physician's Phone	() Physician's Fax		Physician's Address	
II. To be completed by Parent/Gua medication(s) at school according t	Indian: I request and give permissic to school district policy. I give conser	on for my child nt for the school district sta	to receive the abo aff to share information with the physician and/or the	ve

physician's staff as needed to assist my child with medication needs.