

**COLONEL CRAWFORD SCHOOLS
PRESCRIPTION MEDICATION AUTHORIZATION FORM**

HCES: PLEASE KEEP AT HOME FOR FUTURE USE

No prescription will be given by any school personnel unless this form is properly filled out and on file for your child.

PART 1: TO BE COMPLETED BY PHYSICIAN:

Physician's Request for the Administration of Medication by School Personnel

Since medication for the student named below cannot be schedule for other than school hours and the administration of such medication may be supervised/administered by medically untrained personnel, it is requested that the medication as listed below be administered by school personnel.

STUDENT NAME	ADDRESS	SCHOOL
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Is under my care and should receive _____

NAME OF MEDICATION

DOSAGE _____

AT THE FOLLOWING TIMES _____

SPECIFIC INSTRUCTIONS FOR ADMINISTRATION:

POSSIBLE SIDE EFFECTS TO WATCH FOR:

BEGINNING DATE FOR ADMINISTRATION _____

EXPIRATION DATE FOR ADMINISTRATION _____

Physician's Name (please print)

Physician's Signature

Physician's Address Phone

PART 2: TO BE COMPLETED BY PARENT/GUARDIAN

Parent's Request for the Administration of Medication by School Personnel

I hereby request and give my permission to the principal and/or her designee to administer the following medication to my child according to the physician's instructions. I will notify the school of changes of physician's and/or medication, dosage, procedures, or elimination. I will bring the medication in the ORIGINAL prescription container labeled by the physician or pharmacist.

NAME OF CHILD _____

NAME OF MEDICATION _____

DOSAGE _____ at the following times _____

DURATION _____

DATE _____

Signature of Parent/Guardian
