ANNANDALE I.S.D. #876 HEALTH OFFICE
Box 190, Annandale, MN 55302 Phone 320-274-8218 Fax 320-274-8470

AUTHORIZATION FORM FOR MEDICATIONS

(Required for all prescription and non-prescription medications.)

PARENT/GUARDIAN PERMISSION

Student_____ Grade_____ Birthdate_____
Physician Name _____ Clinic_____
Physician Phone_____ Fax_____

I request the medication described below be given to my child at school. I understand that the **medication must be provided to the school in the original, properly labeled container from the pharmacy or physician.** (Duplicate containers can usually be obtained from the pharmacy--one for home and one for school.)
If an inhaler, may child carry and self-administer? Circle: yes no
(If student carries an inhaler, please send an extra to keep in the Health Office.)

Parent/Guardian Signature _____ **Date** _____
Phone Numbers:
Home _____ **Daytime Work** _____ **Cell** _____

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FOR PHYSICIAN OR OFFICE USE ONLY

Medication_____ **Dosage** _____

Amount and time given at school_____

Amount and time given at home_____

Diagnosis for which medication is prescribed_____
Symptoms of Side Effects or Overdose_____
_____
Length of Time to be Administered _____
(All authorizations expire at end of school year.)

Is student knowledgeable about this medication? Circle: Yes No
May student carry and self-administer their inhaler? Yes No

Physician's Signature_____ **Date**_____

Physician's Name (please print)_____**Phone**_____