LATHAM BRAVES

# Moniteau County R-V
# Physician Authorization for Medication

**Student Name** _____ **DOB** _____ **Grade** _____

Parent / Guardian Name _____

Cell Phone _____ Work Phone _____

Prescriber's Name _____

Prescriber's Phone _____ Prescriber's Fax _____

- ❑ I give my permission for verbal and written communication between the physican and the school nurse regarding my child's medication regime.

Parent / Guardian Signature _____ Date _____

## TO BE COMPLETED BY LICENSED PRESCRIBER

**I have determined that it is necessary for this medication to be administered during school hours.**

Medication to be administered _____

Diagnosis/Reason for medication to be administered:

| |
|---|
| |

Route: _____ Dosage: _____ Frequency/time(s) of administration: _____

Potential side effects: _____

Is the student authorized to carry and self-administer this medication at school? _____

Other specific directions or information regarding this medication/administration:

| |
|---|
| |

_____

Signature of Licensed Prescriber

_____

Date