**PARENT AND PHYSICIAN’S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES**

**1) To be completed by the parents or guardian**

 **I request that my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_ GRADE\_\_\_\_**

 **Receive the medication as prescribed below by our physician.**

**The medication is to be personally delivered by me (parent or guardian) in the original labeled pharmacy container stating the specific name of the medication and dispensing orders, or we can use the health office stock bottles of medication.**

**Signature (Parent or Guardian): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone #: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

**2) To be completed by physician**

 **I request that my patient, as listed below, receive the following medication:**

|  |
| --- |
|  ● **Acetaminophen** (see chart) orally, every 4 hours as needed for headache, fever, or pain. |
| Child's weight-lbs. | Dose - mg | **Parent/Guardian Initials for acetaminophen** |
| 60-95 | 325 |
| 95 and over | 650 |
| 151 and over | May have up to 1000mg |
|  ● **Ibuprofen** (see chart) orally, every 4 hours as needed for headache, fever, or pain. |
| Child's weight-lbs. | Dose - mg | **Parent/Guardian Initials for ibuprofen** |
| 48-95 | 200 |
| 96 and over | 400 |
|  ● **Rolaids** or **Tums** 1-2 Tabs orally, every 2 hours as needed |
| For heart burn or upset stomach | **Parent/Guardian Initials for Rolaids or Tums** |

Name of Licensed Prescriber and Title (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescriber’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_