BRIGHTON AREA SCHOOLS

Medication Prescriber/Parent Authorization Form

"Medication" shall include prescription, over-the-counter medication and homeopathic per BAS **Policy #5330** *Use of Medications*

Student Name_____DOB_____School_____Grade_____School Year_____

To be completed by physician/licensed prescriber:

_____Medication Name_____ _Dose_____Time to be given_____Form/Route___Side Effects_____

1._____

2._____

List minimal frequency between doses if PRN/ as needed:_____

If PRN, list symptoms/condition under which medication is to be given:_____

SPECIAL INSTRUCTIONS:_____

Inhaler Use: This student may carry their inhaler and is capable of self administration: Yes_____ No_____

Start Date_____ Stop Date_____

_____ _____ _____

Physician's Signature Date Printed Name

Physician Phone#_____Fax#_____Address_____

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TO BE COMPLETED BY PARENT/GUARDIAN

I request and give permission for (name of child)_____to receive the above medication(s)/treatment at chool according to standard school district policy and for the physician/ staff and school district staff to share information needed to assist my child with medication needs. **The school requires parent/guardian to bring medication in the original container**.

_____ _____ _____

Parent Signature Date Phone Number