517 617-3440

MEDICATION PRESCRIBER/PARENT AUTHORIZATION FORM

HOLT PUBLIC SCHOOLS *teaching excellence*

Student's Legal Name: _____ Birthdate: _____ School Year: _____

To be completed by Physician/Licensed Prescriber:

Medication Name	Dose	Time to be given	Form/Route*	Side Effects	Adverse Reactions

* Routes:
Oral (pill/capsule/chewable, liquid)
Topical eardrop
Injection
Other (list)
Topical (eye drop, ointment)
Inhaled (inhaler, nebulizer)
Topical skin application

If p.r.n., list symptoms/conditions under which medication is to be given: _____

_____ _____ _____
Physician's Signature Date Physician's Printed Name

Physician's Phone: _____ Fax: _____ Address: _____

To be completed by parent/guardian:

I request and give permission for _____ to administer the above medication(s) to my child (named above).
School Name

_____ _____
Parent/Guardian Signature Date