



Physician Authorization and Parental Request for All Medications

Student's Name _____

Grade or Homeroom _____ Date of Birth _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER

Diagnosis/Reason for medication: _____

Name of medication: _____

Medication form: ___ Tablet/Capsule ___ Liquid ___ Inhaler ___ Injection ___ Other: _____

Special Storage Requirements: ___ refrigerate ___ none ___ other: _____

Start date: _____

Stop Date: ___ End of school year ___ Other/duration ___ For episodic/emergency events only

Instructions (schedule and dosage to be given): _____

Restrictions/side effects: _____

If prescribing an **Epipen** or **Rescue Inhaler**, is the student capable and responsible for self-administering this medication? ___ No ___ Yes (supervised) ___ Yes (unsupervised)

May the student carry the **Epipen** or **Rescue Inhaler**? ___ Yes ___ No

Procedure to follow in event medication does not produce expected relief _____

Date: _____ Signature: _____ Authorized prescriber		Date: _____ Reviewed by Nurse: _____
Physician's name printed: _____		
Address: _____		
Phone number: _____ Emergency number: _____		

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for my child, _____ to receive the above medication at school or field trips according to Beaumont School policy. It is understood that Beaumont School and all of its personnel are absolved from any responsibility, which might be associated with the administration of such medication. I understand the medication must be brought to school in its original container or the container to which it was dispensed from the pharmacist.

Date: _____ Signature of Parent/Guardian: _____

Address: _____ Phone Number _____