

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

School Year: \_\_\_\_\_ - \_\_\_\_\_

STUDENT INFORMATION

Student Name: \_\_\_\_\_

School: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

No known drug allergies---if drug allergies list: \_\_\_\_\_

Weight: \_\_\_\_\_pounds

PRESCRIBER AUTHORIZATION (To be comm (c)-2016 of EMC (c)-2016 of EMC (c)-2016 of EMC (c)-2016 of EMC)