# Student Prescription Form

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**This form is to be used on a case by case basis and is only required if and/or when your child needs to take prescribed medication during the school day. This must be signed by the prescriber.**

## STUDENT INFORMATION

Student's Name_______________________________________________________

DOB__________________

School ___________________________________ Grade _____ Teacher ____________

School Year_____-_____

Height (inches) _______ Weight (lbs)_________ List any known drug allergies/reactions

_________________________

__________________________________________________________________________

__________________

## PRESCRIBER AUTHORIZATION

Name of medication ___________________________ Reason for taking

____________________________________

Dosage _______________ Route _________________ Frequency/Time(s) to be given

_______________________

Begin medication (date) ______-_______-_______ End medication (date) ______-_______-

_______

## SPECIAL INSTRUCTIONS

Does the medication require refrigeration: Yes ❑ No ❑

Is the medication a controlled substance: Yes ❑ No ❑

Is self-medication permitted and recommended for this student: Yes ❑ No ❑

**If you marked "yes", then please sign the "Self-Medication Authorization" area below.**

**Potential side effects/contraindications/adverse reactions**

_____________________________________________

_____________________________________________

**Treatment order in the event of an adverse reaction** (attach additional sheet or use the back of this form if necessary).

__________________________________________________________________________

__________________________________________________________________________

| _____________________________ | ________________ | ________________ | _______ |
|---|---|---|---|
| **Prescriber** *(signature)* | **Phone** | **Fax** | **Date** |