

Medication Authorization Form
To be completed by Child's Physician

PLEASE COMPLETE FULLY AND CAREFULLY

School: _____

Child's Name: _____
(Last) (First)

Medications				
Name of Medication:	Purpose of Medication	Dosage Prescribed	Dosage Schedule (routine/as-needed)	Dosage Form (tablet, liquid, etc.)

Precautions, special instructions, possible adverse effect(s), or comments:

Note: The physician providing the information on this form MUST be licensed to practice medicine in California.
 The above named child is under my care:

Physician's Name (print) : Dr. _____ Fax #: _____
(Last) (First) Phone #: _____

Office Name and Address: _____

Physician's Signature: _____ **CA License #:** _____

We hereby authorize the school to administer the above listed medications in accordance with the instructions noted.

Parents Signature: _____ **Date:** _____