Appendix 5280 (See Appendix7240 to 7240.5)

Medication Authorization

Date to Begin Medication___________________________________

Date to Complete Medication________________________________

Student ____________________________________ Date of Birth_________________

School________________________________Grade_____________________

Part I - completed by Student's Physician

I certify that this school must administer medication listed below to my patient

____

Diagnosis

____

Medication

____

Dosage/Mode/Frequency

____

Possible Side Effects

____

Signature of Physician **Printed Name of Physician**

____

Physician Phone Number_____________________ Address_________________________

Part II- completed by Student's Parent/Guardian

I request that the medication listed above be administered to this student in school. I understand that only the school nurse or a school employee trained by the nurse may administer this medicine in school.

___________________________________ __________________

Signature of Parent **Date**