Medication Authorization Form

Please complete one form per medication, as needed.

If your student has **any prescription medications or over-the-counter medications that are not supplied by the school** that will need to be taken during the school day, or during an extended school event (including overnight field trips), please complete the following form.

Student Name: ____

Grade: ________________

Date of Birth: ____/ ____/ _____

Medication Name: ____

Diagnosis/Reason: ____

Dosage: __________________________________

Time(s) of day: __________________________________

Beginning Date: ____/ ____/_____

Ending Date: ____/ ____/ _____

PLEASE NOTE: All medications need to be brought to school in their <u>original container</u> and <u>clearly labeled</u>.

I give permission for Eastern Mennonite School staff to administer the above-named medication to the student named above:

Parent/Guardian Name (print): ____

Parent/Guardian Name (signature): ____

Physician's signature is required if the medication is to be given longer than 10 working days, if the packages states "Consult Physician" or if there is a discrepancy between parents' instructions and label/ packaging instructions.
<u>Always required for Epi-pens and inhalers</u>.

Physician/Provider Name (print): ____

Physician/Provider Name (signature): ____

Physician Phone: ________________

Date: ____/ ____/ _____

If you have any questions about this form, please contact the school at 540-236-6004.
School fax number: 540-236-6028

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