

**Bay City Public Schools
Prescription Medication Authorization Form (Med-1)**

Student Name _____ Birthdate _____ Teacher/Counselor _____ Grade _____ School Year _____

To be completed by parent/guardian:

	<u>Medication</u> <u>(in original container)</u>	<u>Dose</u>	<u>Time To be Given</u>	<u>Form/Route*</u>	<u>Possible Side Effects</u>	<u>Adverse Reactions</u> <u>(Report to Parent)</u>
1						
2						

*Routes—oral (pill/capsule/chewable, liquid)—inhaled (inhaler, nebulizer)—topical skin application—topical (eye drop, ointment) -- topical ear drop—injection—other _____

List symptoms/conditions under which medications ordered as needed (**p.r.n.**) are to be given: _____

If (**p.r.n.**), MINIMUM amount of time between doses: _____

Reason for medication (optional): Medication #1 _____ Medication #2 _____

Special Instructions: _____

Start date: _____ Stop date: _____

Physician's Name: _____ Physician's Phone #: _____

Physician's Address: _____

To be completed by parent/guardian:

I request and give permission for (name of child) _____ to receive the above medication(s) at school according to standard school district policy and for the physician's staff and school personnel to share relevant information regarding my child's medication needs.

Parent/Guardian Signature _____ Date _____