PCSC
Medication Authorization Form

Date of Request: _____ School: _____ Teacher/Grade: _____

Student's Name: _____ Birth Date: _____

Medication: _____ Dosage: _____

Is this the initial dose of a new medication that has not been previously administered to your child? ☐ YES ☐ NO

Time to be Administered: _____ Dates to be Administered: _____

Condition for which medication is required: _____

Special instruction/precaution/side effects of medication on your child:

Physician's Name: _____ Phone: _____

*Physician's Signature: _____

My signature below indicates that I request that PCSC staff administer the medication specified above to my child, and I am giving permission for PCSC staff to contact the physician for additional information, if needed.

Parent/Guardian Signature: _____ Email: _____

Parent's Daytime Phone: _____ Cell Phone: _____

FOR OFFICE USE ONLY!

☐ Entered in Health Office
☐ Teacher notified: _____

Medication Count:

Date	#Pills	Counter's Signature	Witness Initials	Date	# Pills	Counter's Signature	Witness Initials

Comments (Indicated by * on back of form):

Date	Comments	Date	Comments

Date	RN Review

Medication returned to Parent/Student:

_____ _____ _____

Signature Print Name Date