

# Dowagiac Union Schools

## Medication Request and Authorization Form

### 2016-2017 School Year

Student Name: \_\_\_\_\_

DOB: \_\_\_\_\_

School: \_\_\_\_\_

Grade: \_\_\_\_\_

Diagnosis/Reason for Medication: \_\_\_\_\_

<i>Medication</i>	<i>Dosage</i>	<i>Time</i>	<i>Route</i>	<i>Special Instructions</i>

**Student may self-carry EMERGENCY MEDICATION** \_\_\_\_\_  
Physician Signature

Physician Comments (*please list any probable side effects or restrictions*):

\_\_\_\_\_

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\_\_\_\_\_

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\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_  
*Physician's (or Authorized Prescriber) Signature*

\_\_\_\_\_  
*Date*

Physician's (or Authorized Prescriber) Address:

\_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_

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*I have received and understand the Parent Guidelines for Medications at School. I request that my child be given the medications listed above according to the instructions listed, by an authorized staff*

*member at school. I agree to notify the school in writing if the medication, dosage, schedule, or procedure is changed or eliminated, and to provide a new medication form if needed.*

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*Parent Signature*

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*Date*