Farmington Public Schools
AUTHORIZATION FOR MEDICATION FORM

Dear Parent and Physician,

PLEASE READ THE ATTACHED MEDICATION ADMINISTRATION GUIDELINES ON THE BACK OF THE FORM.

PHYSICIAN PLEASE COMPLETE THE FOLLOWING

Student's Name_____

Name of Medication_____Dosage_____

Route Given_____Time_____

Start Date _____End Date_____

Child's diagnosis and reason for medication:
_____

Adverse reactions or side effects:
_____

Additional Comments:
_____

I certify this child requires such medication be given during school hours and that no alternative schedule is medically available.

Physician Signature_____**Date**_____

PrintName_____Phone_____

Address_____

City/State_____Zip_____

Signature_____**Date**_____
Parent/Guardian

PLEASE NOTE: ONLY SECONDARY (GRADE 6-12) STUDENTS MAY SELF-ADMINISTER MEDICATION
This student is both capable and responsible for self-administering this medication according to school policy.

☐ No ☐ Yes – Supervised ☐ Yes – Unsupervised **Physician Initials**_____

Student is authorized to carry this medication ☐ No ☐ Yes

Parent/Guardian_____

☐ Please indicate if you have provided additional information as an attachment.

Revised 2008 **FORM HM 6**