Physician Authorization
Administration of Medication

If medicine is prescribed by a physician, please sign and have the prescribing physician complete this form.

Type of Medication: ____

Date when started: ______________ Reason: ________________________________

Does medication need to be administered at school? _____ Yes _____ No

Prescribing Physician's Name: _______________________________________

____ ______________________
Physician's Signature Date

____ ______________________
Parent's Signature Date

Part of Form 1A: Medical Authorization Form (online at Transparent Classroom), rev. 2/2020