



**ATTENDING PHYSICIAN'S AUTHORIZATION FORM**

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ School Year: \_\_\_\_\_  
 (yy mm dd)

1. Administration of Prescription Medication:  Short term  Long term  
 (under 6 weeks)
- Must be administered by school personnel
  - Must be supervised by school personnel when administered
  - Self administers, no supervision required

Name of Drug: \_\_\_\_\_ Instructions for Storage: \_\_\_\_\_

Specific Directions for Administration:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. Medical Condition of Child:

- Asthma  Diabetes  Seizures  Other: \_\_\_\_\_  
 (Please specify)
- Allergies (please list) \_\_\_\_\_
- Anaphylactic Conditions \_\_\_\_\_

Physician's statement for health care assistance during school hours: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Emergency Response Plan for Condition:

Symptoms of reaction: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Recommended response to reaction: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Name of Physician: (please print) \_\_\_\_\_

Telephone: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_