MEDICATION AUTHORIZATION

- **NO MEDICATION WILL BE GIVEN UNTIL THIS FORM IS COMPLETE**
- **MEDICATION MUST BE DROPPED OFF IN ORIGINAL PHARMACY/MANUFACTURER CONTAINER AND MUST BE LABELED WITH STUDENT'S FULL NAME**
- **PRESCRIPTION MEDICATIONS REQUIRE A PHYSICIAN'S SIGNATURE**
- **ANY INCREASE OR DECREASE OF THE DOSAGE, FOR EITHER PRESCRIPTION OR OVER THE COUNTER MEDICATION, OTHER THAN WHAT IS INDICATED ON THE MEDICATION LABEL, MUST BE AUTHORIZED BY THE PRESCRIBING PHYSICIAN**

Student Name: ____Grade: __________
Siblings authorized to share OTC (Over the Counter) medication:

____

OVER THE COUNTER MEDICATION:____
Reason/circumstances for giving:____
Route: ☐Tablet/Capsule ☐Liquid ☐Inhalation ☐Topical ☐Drops ☐Injection
Dosage:________________________________ Time/Frequency:________________
☐To be administered temporarily. Start date:______________ End date:______________
☐To be administered on an ongoing or "as needed" basis.

OVER THE COUNTER MEDICATION:____
Reason/circumstances for giving:____
Route: ☐Tablet/Capsule ☐Liquid ☐Inhalation ☐Topical ☐Drops ☐Injection
Dosage:________________________________ Time/Frequency:________________
☐To be administered temporarily. Start date:______________ End date:______________
☐To be administered on an ongoing or "as needed" basis.

OVER THE COUNTER MEDICATION:____
Reason/circumstances for giving:____
Route: ☐Tablet/Capsule ☐Liquid ☐Inhalation ☐Topical ☐Drops ☐Injection
Dosage:________________________________ Time/Frequency:________________
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OVER THE COUNTER MEDICATION:____
Reason/circumstances for giving:____
Route: ☐Tablet/Capsule ☐Liquid ☐Inhalation ☐Topical ☐Drops ☐Injection
Dosage:________________________________ Time/Frequency:________________
☐To be administered temporarily. Start date:______________ End date:______________
☐To be administered on an ongoing or "as needed" basis.

See reverse for prescription meds and physician signature.

PRESCRIPTION MEDICATION:______________________________
Reason/circumstances for giving:______________________________
Route: ☐Tablet/Capsule ☐Liquid ☐Inhalation ☐Topical ☐Drops ☐Injection
Dosage:______________________ Time/Frequency:______________
☐To be administered temporarily. Start date:__________ End date:__________
☐To be administered on an ongoing or "as needed" basis.

PRESCRIPTION MEDICATION:______________________________
Reason/circumstances for giving:______________________________
Route: ☐Tablet/Capsule ☐Liquid ☐Inhalation ☐Topical ☐Drops ☐Injection
Dosage:______________________ Time/Frequency:______________
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PRESCRIPTION MEDICATION:______________________________
Reason/circumstances for giving:______________________________
Route: ☐Tablet/Capsule ☐Liquid ☐Inhalation ☐Topical ☐Drops ☐Injection
Dosage:______________________ Time/Frequency:______________
☐To be administered temporarily. Start date:__________ End date:__________
☐To be administered on an ongoing or "as needed" basis.

PRESCRIPTION MEDICATION:______________________________
Reason/circumstances for giving:______________________________
Route: ☐Tablet/Capsule ☐Liquid ☐Inhalation ☐Topical ☐Drops ☐Injection
Dosage:______________________ Time/Frequency:______________
☐To be administered temporarily. Start date:__________ End date:__________
☐To be administered on an ongoing or "as needed" basis.

For all prescription medication or dosage changes for OTC medication, I authorize Eastbrook Academy to administer medication as prescribed to the student whose name appears on this form and I also agree to accept communication regarding the administration procedures, if needed.
Student is able to self-administer unassisted. ☐Yes ☐No

____
Name and Signature of Prescribing Physician Date

☐Authorized school personnel have my permission to administer the medication(s) listed above.
☐I release Eastbrook Academy and its employees from all liability which may result from acting on this request.
☐It is understood the medication will be given by specially trained personnel only.
☐I also agree to inform the school in writing of any changes or discontinuation of this order.
☐I understand the medication will be medically disposed of if not picked up after 10 days.

____
Name and Signature of Parent/Guardian Date