

Fabius-Pompey Elementary School  
7800 Main Street  
Fabius, New York 13063  
(315) 683-5197  
(315) 683-5680 FAX

**MEDICATION AUTHORIZATION FORM**

To: Physicians/health care providers and parents/guardians of children requiring medication in school.

If it is necessary for your child to take medication (prescription and non-prescription) during school hours, it is requested you fill out the form below and return it to the nurse's office in your child's school.

Medication needs to be delivered to the school nurse in its **PROPER LABELED CONTAINER!**

**Physician/health care provider and parent SIGNATURES are required!**

Please note that most medications prescribed 3 times a day may be taken at home. (Before school, after school & evening).

Health care providers PLEASE complete:

School Health Office

Please dispense the following medication to: \_\_\_\_\_.

DURING SCHOOL HOURS: \_\_\_\_\_.

**Name of medication:** \_\_\_\_\_

**Dosage/Time:** \_\_\_\_\_

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

Dates to be given, Discontinued

OR

Effective throughout school year: \_\_\_\_\_

**Date:** \_\_\_\_\_ **Health Care Provider Signature:** \_\_\_\_\_

**Health Care Provider Print Name:** \_\_\_\_\_

I request that the school health personnel administer medication prescribed to: \_\_\_\_\_.

**Child's D.O.B.:** \_\_\_\_\_ **Child's Grade:** \_\_\_\_\_

**Child's Allergies:** \_\_\_\_\_ **Relationship to Child:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_

**Parent/Guardian Phone Number:** \_\_\_\_\_