DEVINE INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICE DEPARTMENT

PRESCRIPTION MEDICATION AUTHORIZATION FORM

This is for medications that have been prescribed by a physician.
The following is to be filled out by the parent/guardian:

Student:_____ , _____ Sex: ____ Grade: _____
Last First

Physician's Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip:_____

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons.

_____
Parent/Guardian Signature Printed Name

Date: _____ Phone: _____

The Following must be completed by a Physician.

Diagnosis for which the medication is being prescribed: _____
_____
Name of Medication: _____
Dosage to be given: _____
Special Instructions: _____

When Prescribed medication to be given to the student. Please check one below and fill out further instructions.

- ☐ Daily Time of Day _____
- ☐ As Needed Frequency _____

Describe indications if as needed: _____

List significant side effects:_____

Length of time this treatment is recommended: _____

Other Information: _____

_____ _____
Physician Signature Date

Updated 6/15/23 KK