

**DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH
SCHOOL HEALTH PROGRAM
STUDENT HEALTH AUTHORIZATION FORMS**

Name of Student: _____ Date of Birth: _____
School: _____ Social Security #: _____
Grade: _____

PART I: PARENT/GUARDIAN CONSENT FORM

Parent/Guardian: *Please complete and sign this form.*

I hereby request and authorize the school nurse/licensed practical nurse/certified DCPS personnel to administer prescribed medications as directed by the physician to my son/daughter.

Student's Name

I have read the procedures on the reverse side of this form and agree to assume responsibilities as required. This medication is a _____ new or _____ renewed prescription. *If this is a new prescription, enter the date and time of first dose given at home.*

Date: _____ Time: _____ A.M. _____ P.M. _____

Name of Parent/Guardian: _____ Date: _____

Please Print

Signature of Parent/Guardian

Relationship

Please take this form to the student's physician for completion

PART II: PHYSICIAN'S MEDICATION AUTHORIZATION ORDER

Physician: *Please complete and sign this medication authorization order.*

Please check one: _____ Original _____ Renewal _____ Change

Name of Student: _____ Date of Birth: _____

Diagnosis: _____ Telephone #: _____

Name of Medication: _____

Dose: _____ Time and
circumstances of administration at school _____ Expected duration of
administration _____

Can reaction be expected? _____ Yes _____ No If yes, please describe:

Physician's Name: _____

Physician's Address: _____

Telephone Number: _____

Physician's Signature: _____ Date: _____

School Nurse

DCPS Qualified Staff