HEAD-ROYCE SCHOOL
PRESCRIPTION/OVER-THE-COUNTER MEDICATION AUTHORIZATION FORM

STUDENT'S LAST NAME	FIRST NAME	DATE OF BIRTH

- **Parent and physician/health care provider must complete, sign, and submit a copy of this form to the school nurse before any prescription, or self-carry over-the-counter medication, can be administered to the student during school or school-sponsored trips.**

This student is both capable and responsible for carrying and self administering this medication.*
[ ] **Yes** [ ] No **(Student is permitted to carry and self administer asthma inhalers, epi-pens, and other physician/health care provider ordered medication; required form needs to be on file in the health office).**

PRESCRIPTION/OVER-THE-COUNTER MEDICATION				
MEDICATION	DOSAGE/ROUTE	TIME(S) TAKEN	REASON	SPECIAL INSTRUCTION(S)

I authorize Head-Royce School, through its employees or agents, to provide the medication indicated above consistent with the instructions set out in the chart above.

Parent/Guardian Signature Required______________________________________Date_____________

Physician/Healthcare Provider Signature Required_________________________Date_____________

Physician's Address ____

Physician's Phone Number ____

3/2019