Authorization for Dispensing Medication

Part I: To Be Completed by Physician

Child's Name: _____ Diagnosis: _____

_____	_____	_____	_____
Medication	Route of administration	Dosage	Time/Frequency

If PRN, state frequency or indication: _____

Duration of treatment: _____

Possible side effects and adverse reactions: _____

_____

Other recommendations: _____

_____

Is this drug covered by the psychotropic drug law? _____ Yes _____ No

_____	_____
Physician's Name (printed or typed)	Telephone number
_____	_____
Physician's signature	Date

Part II: To Be Completed by Parent/Guardian

I authorize the nurse to see that my child _____ receives the medication prescribed by _____.

_____	_____
Parent's/guardian's name (printed or typed)	Telephone number
_____	_____
Parent's/guardian's signature	Date

Please list all medications that your child is taking at home:

_____

_____

_____