**PHILLIPS School~Fairfax**
**11230 Waples Mill Road, Suite 100**
**Fairfax, VA 22030**
**Phone (703) 591-1146**
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# PHYSICIAN'S MEDICATION AUTHORIZATION FORM

*One form must be completed for each medication administered*

The parent/guardian of ______________________________ ask that PHILLIPS administer the following
(Child's Name)

medication ______________________________________________ at ___________________________.
(Name of Medication and Dosage) (Time)

PHILLIPS agrees to administer the below medication in accordance to instructions provided below by the prescribing physician. It is the parent/guardian's responsibility to furnish the medication to PHILLIPS. The parent agrees to pick up expired or unused medication within one week of notification by PHILLIPS' staff. If medications are not picked up within a week, PHILLIPS will destroy the medication in accordance with the standards set forth by MATY.

Prescription Medications must be delivered by the parent/guardian to PHILLIPS in the pharmaceutical container provided by the pharmacy, labeled with the student's name, name of medicine, time medication is to be given, dosage, and the name of the prescribing physician.

Over-the-Counter Medication must be delivered by the parent/guardian to PHILLIPS in the original, unopened, packaged container and labeled with the student's name. The dosage of the provided medication must match the dosage indicated on the signed Over the Counter Medication Authorization form.

By signing this document, I give permission for my child's physician to share information about the administration of this medication with PHILLIPS staff delegated to administer medication.

| ______________________ | ______________________ | ______________ |
|---|---|---|
| Parent/Guardian Name | Parent/Guardian Signature | Date |
| ______________________ | ______________________ | ______________ |
| Phone (Cell) | Phone (Work) | Phone (Home) |

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## Physician's Authorization to Administer Medication at PHILLIPS

Student's Name: ______________________________ DOB: ______________________

Medication: ______________________________

Dosage: ______________ Route: ______________

To be administered at the following time(s): ______________________________

Special Instructions: ______________________________

Purpose of medication: ______________________________

Side effects that need to be reported: ______________________________

Starting Date: ______________________ Ending Date: ______________________

| ______________________ | ______________________ | ______________ |
|---|---|---|
| Signature of Prescribing Physician | Physician's Phone | Date |

This form must be updated whenever a student receives a new medication, or when a physician alters the dosage or time of distribution.

*Form received & reviewed by PHILLIPS staff:* ____________