Revolution Academy Medication Authorization Form

For Prescription and Non-prescription Medications

Instructions:

- **Section A** must be completed by the parent/guardian for **ALL** medication authorizations
- **Sections A and B** must be completed for any long-term medication authorizations (those lasting longer than 10 school days including but not limited to rescue inhalers, Epi-pens etc.).

Section A: To be completed by parent/guardian

Medication authorization for: _____ DOB: _____/_____/_____
(Child's Name)

Revolution Academy has my permission to administer the following medication(s)

Medication name: _____

Dosage and times to be administered: _____

Special Instructions: _____

This authorization is effective from: _____ until: _____
(Start Date) **(End Date)**

Parent or Guardian Name (please print): _____

Parent or Guardian Signature: _____

Section B: To be completed by child's Medical Provider

I, _____ certify that it is medically necessary for the
(Name of Medical Provider)

medication(s) listed below to be administered to: _____
(Child's Name)

For a duration that exceeds 10 school days. Medication name: _____

Dosage and times to be administered: _____

Special Instructions (if any): _____

This authorization is effective from: _____ until: _____
(Start date) **(End date)**

Medical Provider's Phone Number: ( ) _____ Date: _____

Medical Provider's Signature: _____