RUMSEY HALL SCHOOL

MEDICATION AUTHORIZATION FORM

- A physician must complete all medication sections below, then sign and date this form
- **A separate form is required for each medication** administered at the Rumsey Hall Health Center. Print additional forms as needed
- After completion, the physician must return the form to the parent
- Parents must review, sign, and upload the form to their child's Magnus Health account

STUDENT INFORMATION:

Student Name:	**Date of Birth:**

PHYSICIAN INFORMATION:

Printed Physician Name:	**Physician Phone #:**
Physician Signature:	**Date Signed:**

MEDICATION INFORMATION:

Allergies:	
Medication Name:	
Generic Name*:*	
Diagnosis:	
Medication Dosage *(mg, mcg, ml):*	
Route:	
Frequency of Dosage: ☐ **Once Daily** ☐ **BID** ☐ **TID** ☐ **QID**	
Time of Dosage: ☐ **AM** ☐ **Lunch** ☐ **Dinner** ☐ **Other**	
Is Dosage a PRN? *(as needed)* ☐ **No** ☐ **Yes**	☐ **Check if PRN on Weekend/Non-Academic Days Only**
Medication Administration Dates:	**From:** / / **mm / dd / yyyy** **To:** / / **mm / dd / yyyy**

PARENT INFORMATION:

Parent Signature: ***I have reviewed the above information and confirmed its accuracy.***	**Date Signed:** / / **mm / dd / yyyy**