



## Doctor's Authorization for Prescription Medicine

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

The above is under my medical supervision. I have ordered the following medication(s):

Medication: \_\_\_\_\_

Dosage \_\_\_\_\_ Time \_\_\_\_\_  
\_\_\_\_\_ at \_\_\_\_\_

\_\_\_\_\_ at \_\_\_\_\_

Medication: \_\_\_\_\_

Dosage \_\_\_\_\_ Time \_\_\_\_\_  
\_\_\_\_\_ at \_\_\_\_\_

\_\_\_\_\_ at \_\_\_\_\_

Reason for medication to be administered at TCA \_\_\_\_\_

\_\_\_\_\_

Possible reactions or side effects \_\_\_\_\_

\_\_\_\_\_

Date prescription expires \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Doctor's Stamp \_\_\_\_\_

Phone Number \_\_\_\_\_ Date \_\_\_\_\_