



PROVIDER MEDICATION AUTHORIZATION FORM

SCHOOL YEAR: 26'-27'

Student: \_\_\_\_\_

DOB: \_\_\_\_\_

Name of medication:	Reason for taking medication:	Medication Dosage & Strength	Route	Time(s) to be given:
Tylenol (Acetaminophen)	<input type="radio"/> Headache <input type="radio"/> Menstrual cramps <input type="radio"/> Musculoskeletal pain <input type="radio"/> Toothache <input type="radio"/> Fever reducer <b>*given before student goes home</b> <input type="radio"/> Other _____	<input type="radio"/> 500 mg <input type="radio"/> 1,000 mg	<input type="radio"/> Oral	<input type="radio"/> Every 4-6 hours as needed for associated symptom(s)
Ibuprofen	<input type="radio"/> Headache <input type="radio"/> Menstrual cramps <input type="radio"/> Musculoskeletal pain <input type="radio"/> Toothache <input type="radio"/> Other _____	<input type="radio"/> 200 mg <input type="radio"/> 400 mg <input type="radio"/> 600 mg <input type="radio"/> 800 mg	<input type="radio"/> Oral	<input type="radio"/> Every 4-6 hours as needed for associated symptom(s)
Benadryl	<input type="radio"/> Allergy relief	<input type="radio"/> 25 mg	<input type="radio"/> Oral	<input type="radio"/> Every 4-6 hours as needed for associated symptom(s)

The undersigned parent(s) or guardian(s) hereby agree(s) to release Colorado Early Colleges Aurora and its personnel from all claims, which they now have or may hereafter have arising out of the release of the medication to the student.

Healthcare Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

School Nurse Signature: \_\_\_\_\_

Date: \_\_\_\_\_