

MEDICATION AUTHORIZATION FORM – ADHD TREATMENT (Exchange Student – USA)

STUDENT INFORMATION

Student Name: _____
Date of Birth: _____ Gender: _____
School / Exchange Program: _____

MEDICATION INFORMATION (ADHD)

Medication Name (Generic & Brand): _____
Dosage: _____ Route: _____
Administration Time(s): _____
Indication: Attention-Deficit / Hyperactivity Disorder (ADHD)
Possible Side Effects: _____
Special Instructions: _____

PHYSICIAN AUTHORIZATION

I certify that the above-named student requires this medication during school hours and is medically stable to participate in school activities while under treatment.

Physician Name: _____
Medical License Number: _____
Address: _____
Phone: _____

Physician Signature: _____ Date: _____

PARENT / LEGAL GUARDIAN AUTHORIZATION

I authorize the school nurse or designated school personnel to administer the above medication as prescribed and release the school from liability related to medication administration.

Parent / Guardian Name: _____
Signature: _____ Date: _____

STUDENT CONSENT (if applicable)

I agree to follow the medication instructions as prescribed.

Student Signature: _____ Date: _____