ALABAMA STATE DEPARTMENT OF EDUCATION

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

School Year: _____-_____

STUDENT INFORMATION

Studentôs Name: _____ School: _____

Date of Birth: _____/_____/_____ Age: _____ Grade: _____ Teacher: _____

☐ No known drug allergies---if drug allergies list: _____ Weight: _____pounds

PRESCRIBER AUTHORIZATION (To be comm (c)-2(o)7.1 refEMC (c)-2(o)7.1 refEMC (c)-2(o)7.1 refEMC (c)-2(o)7