



**FRISCO INDEPENDENT SCHOOL DISTRICT**

*Special Education Services*

**PHYSICIAN AUTHORIZATION FOR HERBAL AND DIETARY SUPPLEMENT ADMINISTRATION**

Student's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Campus: \_\_\_\_\_ Grade: \_\_\_\_\_ ID#: \_\_\_\_\_ Sex: \_\_\_\_\_

Student's Primary Care Physician: \_\_\_\_\_

**TO BE COMPLETED BY THE STUDENT'S PRIMARY CARE PHYSICIAN**

Student's Medical Diagnosis: \_\_\_\_\_ Body Weight: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_ Date of most recent physician's visit: \_\_\_\_\_

**Physician recommended Herbal and Dietary Supplement(s) to be administered during the school day:**

Name of Herbal and Dietary Supplement(s): \_\_\_\_\_ Dosage: \_\_\_\_\_

Time Range of Administration and Route: \_\_\_\_\_

This product & requested dosage are safe for the student (considering the age, body weight, and condition):  Yes  No

The Herbal and Dietary Supplement **MUST** be administered during school hours:  Yes  No

Special requirements of administration (with food, empty stomach, etc.): \_\_\_\_\_

Expected benefits of Herbal and Dietary Supplement: \_\_\_\_\_

Potential adverse or untoward effects of Herbal and Dietary Supplement: \_\_\_\_\_

**NOTE:** *Adjustments in the administration protocol or discontinuation of the herbal or dietary supplement requires a written signed physician's order and agreement by the ARD/IEP committee. Orders must be renewed each school year.*

***The printed name / signature of a licensed physician is required. Please include phone # below.***

\_\_\_\_\_  
PRINTED NAME OF LICENSED PHYSICIAN

\_\_\_\_\_  
SIGNATURE OF LICENSED PHYSICIAN

\_\_\_\_\_  
PHONE NUMBER OF LICENSED PHYSICIAN

\_\_\_\_\_  
DATE SIGNED BY LICENSED PHYSICIAN

\_\_\_\_\_  
FAX NUMBER OF LICENSED PHYSICIAN

**TO BE COMPLETED BY PARENT**

I hereby give permission for school personnel and/or the school nurse to consult with the prescribing physician regarding the administration of this herbal and/or dietary supplement.

I hereby request that my child, \_\_\_\_\_, be given the above named herbal and/or dietary supplement as prescribed by my child's personal care physician.

\_\_\_\_\_  
**PRINTED NAME OF PARENT**

\_\_\_\_\_  
**SIGNATURE OF PARENT**

\_\_\_\_\_  
**PRINTED NAME OF PARENT**

\_\_\_\_\_  
**SIGNATURE OF PARENT**