AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

PARENT'S/GUARDIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION (PRESCRIPTION OR OVER-THE-COUNTER) BY SCHOOL PERSONNEL

Date: _____

_____(child's full name), who is in the

_____ grade at the _____ School must take medication which has

been prescribed to be administered during the school day.

Name of medication (as it appears on the original container) _____

Dosage and time to be given _____
(Indicate if medication is to be given as needed, for example: every 4 hours as needed)

Date administration of drug is to begin _____

Special instructions for the administration and storage of this drug _____

_____

Name of physician _____

Physician phone number _____

I request/authorize the school to give medication to my student in accordance with the health care provider's instructions written above. I understand that unlicensed staff may be assigned to provide medication to my student, and I accept ultimate responsibility for monitoring the effects of this medication.

_____ _____

Date **Parent/Guardian Signature**

Phone: _____ _____ _____

Home **Cell** **Work**