School District Name

Parent/Guardian Authorization for Medication Administration at School

- **Written authorization from parent/guardian is required for all medications given at school.**
- **Written authorization from a licensed health care provider is required for all prescription medications given at school.**

Student Name: _____

Medication and Dose: _____

Time medication is to be given: _____

How is medication taken?

_____Oral _____Applied to skin _____Inhaled _____Instilled in eyes or ears Other: _____

Why is medication to be given: _____

_____

Start date: _____

End date: _____

Special storage requirements: _____

Possible side effects: _____

_____

Medications will be brought to school by an adult and will be in the originally labeled pharmacy or manufacturer's container. Medication will only be released to an adult. Medication not claimed by the parent/guardian at the end of the year will be discarded in an appropriate manner.

The *(School Name)* has permission to contact the prescribing health care provider about this medication.

I give *(School Name)* permission to administer the above medication to my child.

_____ _____

Parent/Guardian Signature Date