



Laramie County School District #2

Medication Authorization /Administration Form

School Nurses 307-245-4160 or 307-245-4166

Child's Name _____ Grade _____ Date _____

Medication Name _____

Dosage _____ Time/Frequency _____

Reason for medication _____

Possible side effects _____

Special instructions _____

Estimated Termination Date _____

(All authorizations expire at the end of the school year.)

Physician prescribing _____

Physician's address _____ Phone number _____

I request this medication be given to my child _____

as prescribed by my child's physician.

Parent/Guardian Signature _____ Date _____