Authorization for Medication Administration

Student's Name_____ DOB_____ Grade_____School Year _____

**********TO BE COMPLETED BY HEALTHCARE PROVIDER********

Please list any prescription medication(s) that may need to be administered during school hours or school related activities.
To be completed and signed each year by healthcare provider and parent/guardian.

Medication			
Dosage/Route			
Time/Frequency			
Reason for Medication			
Special Instructions			
Start/Stop Dates			
Side Effects to Report to Physician			

_____

Signature of Physician Printed Name Date

_____

Physician Address Phone Number

**********TO BE COMPLETED BY PARENT/GUARDIAN********

The above medication will be furnished by parent or guardian in a container properly labeled by a pharmacist with identifying information, (e.g. name of child, medication, dosage to be given, and the time it is to be given)

I hereby give my permission for my child (named above) to receive medication during school hours. I understand that the school undertakes no responsibility for the administration of the medication. This medication has been prescribed by a licensed physician and I hereby release the school and its employees from any and all liability that may result from my child taking this medication. I request that my child be administered the prescription medication (per school personnel or self) as indicated in the physicians' order above. The parent/guardian must notify the nurse or designee in writing of any changes regarding the change of treating physician, medication, dosage, time, and/or discontinuation.

_____

Signature of Parent/Guardian Date

**********FOR OFFICE USE ONLY********

_____ Med brought in appropriate container _____ # tablets _____Expiration Date

_____

Date Received School Nurse