FORM A

—SCHOOL CITY OF MISHAWAKA—
AUTHORIZATION TO ADMINISTER MEDICATION FORM

Student Name:_____ **Date** _____

NON-PRESCRIPTION (over the counter) MEDICATION
Parent/guardian must complete this section and ***send the medicine to school in the original container.***

Medicine Name: _____

Dosage must be consistent with recommended dosage on the container and age appropriate.

_____

Time of day to administer the medication: _____

PRESCRIPTION MEDICATION
Parent/ guardian must sign below. The doctor must sign below if it is a prescription medication. The medicine must be brought to school in the original container. All medications must be FDA approved and be required to be given during the school day, which means they can not be given at home. (example, lunch time medication)

Medicine Name: _____

Dosage: _____

Time of Day to Administer: _____

Termination Date of Prescription: _____

Side Effects, if any:_____

Physician/Practitioner Signature: _____

Physician/Practitioner Name PRINTED:_____

PARENT/GUARDIAN APPROVAL
This certifies that I, the undersigned patent/guardian am aware of the above authorization and hereby request that it be carried out by assigned school personnel. I agree to notify you immediately of any changes in circumstances concerning the administration of this medication.

Signature of Parent/Guardian:_____ Date:_____

TERMINATION OF MEDICATION
I hereby withdraw consent for my child to receive the above medication while at school.

Signature of Parent/Guardian:_____ Date:_____

All Medication must be kept in the health office. Students are not permitted to carry medication in their possession.

This form is in compliance with School City of Mishawaka Policy 5330

Revised 10/12