

**AUTHORIZATION TO ADMINISTER PRESCRIPTIVE MEDICATION**  
**PHYSICIAN'S STATEMENT**

I have prescribed the medication indicated below for: \_\_\_\_\_  
and do hereby authorize the nurse or principal, or their designee, (i.e. secretary), of  
\_\_\_\_\_ school, to administer the medication as indicated.

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

The above named student may carry the prescribed **EMERGENCY** medication for  
self-administration (circle one)                      **YES**                      **NO**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Physician's Name (printed)

\_\_\_\_\_  
Physician's Phone Number

**PARENT'S AUTHORIZATION**

I do hereby authorize the person(s) designated by the above physician to administer this medication  
for my child, \_\_\_\_\_, as prescribed above.

I further understand that I will be responsible for supplying this medication to the school in the  
original pharmacy labeled container.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Address

**PLEASE NOTE:**    The Physician's Statement and the Parent's Authorization are valid only  
for the current school year. **Unless the authorization and statement  
are renewed, the medication cannot be given to the student.**

**TO BE PLACED IN LOCKED STORAGE AREA WITH THE PRESCRIPTION MEDICATION**