AUTHORIZATION TO ADMINISTER MEDICATION IN SCHOOL

(TO BE KEPT CONFIDENTIAL UPON COMPLETION)

NAME OF STUDENT: _____ GRADE: _____

DIAGNOSIS/ILNESS: _____

MEDICATION: _____

DOSAGE: _____ FREQUENCY: _____

SPECIAL DIRECTIONS: _____

POSSIBLE SIDE EFFECTS: _____

* *

I certify that the above information regarding this student is correct, and that administration of the medication to this student is necessary.

_____ _____

(Signature of Prescribing Physician) (Date)

_____ _____

(Address) (Phone)

* *

I/we authorize the school nurse or, in his/her absence, the principal to administer the above mediation as indicated. I/we understand and agree that the school, the school nurse and the principal shall not be liable for any injury to the student resulting from the administration of the medication as authorized by my signature below.

_____ _____

(Signature of Parent/Guardian) (Date)

_____ _____

(Signature of Parent/Guardian) (Date)