Authorization for Administration of Medication at School

Name of Student:_____ Birth Date:_____

School:_____ School Year:_____ Grade:_____

Medical Condition	Medication	Dosage	Times	Route	Possible Side Effects

Start Date_____**Stop Date**_____
(All authorizations expire at the end of the school year)

_____ _____
Physician's Name **Physician's Signature**

_____ _____
Clinic Address **Clinic Phone Number**

Parent / Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by this student's physician. I also request the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the even adverse reactions result from taking the medication(s).
3. I will notify the school of any changes in the medication(s). (Ex.: dosage change, discontinued, etc.)
4. I give permission for the school nurse to communicate with the student's teachers about the student's health condition(s) and the action of the medication(s).
5. I give permission for the school nurse to consult with the above named student's physician regarding any question that arises with regards to the medication(s) and health condition(s) described above.
6. I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.

_____ _____ _____
Date Parent/Guardian Signature Relationship to Student

NOTE: Medication is to be supplied in the original, labeled prescription bottle/container.