KIRKWOOD
SCHOOL DISTRICT

AUTHORIZATION FOR MEDICATION ADMINISTRATION

Student Name: _____ Building: _____

Parent/Guardian: _____ Student Grade: _____

As Parent/Guardian of my child, I hereby request that my child receive the following medication at school:

Medication: _____

Dosage: _____

Reason: _____

Time Schedule: _____

Comments: _____

_____

_____

I understand that:

- Medication must be in the original container.
- Prescription drugs must be labeled by Pharmacist and include name, dosage, amount of medication and doctor's name.
- I am responsible for monitoring medication supply and obtaining refills.
- Parent/Guardian must hand deliver the medication to the school clinic.
- I will notify school personnel in writing of any change in dosage and/or time medication is to be given.

PARENT/
GUARDIAN SIGNATURE: _____ DATE: _____