Michigan City Area Schools
Opportunity ★ Excellence ★ Pride

Form #241
Rev. 9/25

AUTHORIZATION TO ADMINISTER PRESCRIPTIVE MEDICATION

PHYSICIAN'S STATEMENT

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

Medication: _____

Dosage: _____

Time to be given at school: _____

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

_____ _____
Date Physician's Signature

_____ _____
Physician's Phone Number Physician's Printed Name

PARENT'S AUTHORIZATION

I do hereby authorize the person(s) designated by the above physician to administer this medication to 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