AUTHORIZATION FOR MEDICAL ADMINISTRATION BY SCHOOL PERSONNEL

Student Name: _____ DOB: _____ Grade: _____

I am giving school personnel permission to administer medication to my child per the following: (parent please complete)

MEDICATION: _____

Prescription* _____ Non-Prescription _____ (check one)

Dose (how much): _____

Frequency (how often): _____

Time (is there a specific time your child needs medication?): _____

Duration: Start date _____ End date _____

Reason for Medication: _____

Special Instructions: _____

- I understand I am responsible to provide this medication and maintain the supply as needed.
- I understand I am responsible to notify the school in writing of any changes.
- Parents are required to pick up all unused medication by the last day of school.
- All medication left at the school will be discarded.

PARENT/GUARDIAN SIGNATURE _____

DATE _____

(*This authorization applies only to the medication listed above and for the duration of treatment or school year. This authorization also authorizes an exchange of information, as necessary, between the school nurse, appropriate school personnel, and/or my child's health provider.)*

* PHYSICIAN DIRECTION REQUIRED ON PHARMACY LABEL FOR ALL PRESCRIPTION MEDICATIONS.