



Authorization to Administer Medication at School

Student's Name:	Birth Date:
Medication:	
Dosage:	Route:
To be Given at the following time(s):	
Purpose of Medication:	
Special Instructions:	
Possible side effects:	
Print Physician's Name:	
<div style="display: flex; justify-content: space-between; border-top: 1px solid black; margin-top: 10px;"> _____ _____ </div>	
Physician's Signature	Date
<p>I give permission for the above listed medication to be dispensed to my child by school personnel as prescribed. I release the school from any responsibility for side effects or other medical consequences of this medication. It is my responsibility to furnish the medication in the original labeled container. I agree to pick up expired or unused medication within one week of notification by school staff.</p>	
<div style="display: flex; justify-content: space-between; border-top: 1px solid black; margin-top: 10px;"> _____ _____ </div>	
Parent/Legal Guardian Signature	Date

The school agrees to administer the above medication as prescribed by the licensed healthcare provider. This authorization is in effect for the current school year only.

Prescription medications must come in an original pharmacy labeled container with child's name, name of medicine, time medicine is to be given, dosage, date and licensed healthcare provider's name. Please ask the pharmacist for a separate medicine bottle to keep at school.

Over the counter (FDA approved) medications must be labeled with child's name and packaged in original container. Dosage must match the signed licensed healthcare provider's authorization.