JEFFERSON SCHOOLS
MEDICATION AUTHORIZATION FORM
(For all prescription and non-prescription medications)

Student Name:_____ Grade_____

Attending Physician:_____ Phone_____

Physician Address:_____

Prescription:
Name of Medication _____
Dosage and frequency _____
Time of Administration _____
Anticipated Duration _____
Purpose of Medication _____
Possible Side Effects _____

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I hereby request that my child be administered the above medication at school by the school personnel authorized by the principal. I understand that the medication will be administered exactly as per the instructions of my above named physician. I will notify the school of changes or discontinuation of this medication.

I will provide a single dose of medication (prescription or non-prescription) in a labeled, original container to be taken by my child when involved in an activity during regular school hours which takes place outside of his/her home building.

Parent or Guardian Signature_____ Date_____

Physician Signature_____ Date_____

This form must be kept with the medication until discontinuation or until the end of the school year and then filed in the cumulative record.

_____ _____
Principal Signature School Nurse Signature

Date_____ Date_____