AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

NAME OF STUDENT_____ BIRTHDATE_____

ADDRESS_____ PHONE_____

_____

SCHOOL_____ GRADE _____

PART I - PHYSICIANS STATEMENT (Complete in full)

1. Name of Medication_____
2. Dosage/amount to be given_____
3. Frequency/times to be administered_____
4. Duration (week, month, indefinite, etc.)_____
5. Anticipated reaction to medication (Symptoms, Side Effects, etc.)_____

   _____
6. Reason for this Medication_____

_____

Physician's Signature Address Phone Date Signed

Part II - PARENT'S REQUEST/APPROVAL

I hereby request and give my permission for the above named school to administer the medication prescribed on this form to my child.

_____ _____

Parent/Guardian **Date signed**

Part III – DESIGNATED PERSON(S) ADMINISTERING MEDICATION

I have agreed to administer the medication as requested by the parents and in accordance with the directions listed above by the physician.

_____ _____

Signature of School District Employee Administering the Medication **Date signed**

This form must be completed before any medication will be dispensed from the school office. All medications must be clearly marked and in the original containers. In the event the medication in question is not a prescribed medication (ex. Pain Relievers, Aspirin, etc.), please complete all sections to ensure medication will be dispensed properly.

All medications and refills must be brought to the school office by a parent or guardian. This will ensure that no medication is transported by students. Thank you for your cooperation.