

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

Name of Student _____ Birthdate _____

Address _____ Phone _____

School _____

PART 1: Physician's Statement

1. Name/type of medication _____

2. Dosage/amount to be given _____

2. Frequency/times to be administered _____

3. Duration (week, month, indefinite, etc.) _____

4. Anticipated reaction to medication _____

5. Symptoms, side effects, etc. _____

Physician's Signature _____

Address _____

Phone _____

Date Signed _____

Part II. Parent's Request/Approved

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

Parent's Signature _____

Date Signed _____