

Authorization for Administration of Medication at School

Name of Student: _____ Birth Date: _____

School: _____ School Year: _____ Grade: _____

Medical Condition	Medication	Dosage	Times	Route	Possible Side Effects

Start Date _____ Stop Date _____
 (All authorizations expire at the end of the school year)

 Physician's Name

 Physician's Signature

 Clinic Address

 Clinic Phone Number

Parent / Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by this student's physician. I also request the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
3. I will notify the school of any changes in the medication(s). (Ex: dosage change, discontinued etc.)
4. I give permission for the school nurse to communicate with the student's teachers about the student's health condition(s) and the action of the medication(s).
5. I give permission for the school nurse to consult with the above named student's physician regarding any question that arise with regards to the medication(s) and health condition(s) described above.
6. I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.

 Date

 Parent/ Guardian Signature

 Relationship to Student

NOTE: Medication is to be supplied in the original, labeled prescription bottle/container.

