



Authorization to Administer Medication at School

Name of Student _____ Date of Birth: _____
Grade/Teacher _____
Clinic: _____
Physician's Name: _____

**INSTRUCTIONS FOR PRESCRIPTION MEDICATION TO BE FILLED
OUT BY PHYSICIAN**

In my opinion, it is necessary to administer this medication during the school day.

Medication: _____ Dosage: _____
Time to be Given: _____ Route: _____
Duration to be Given: _____
Purpose of Medication: _____

Date: _____ Physician's Signature: _____

**INSTRUCTIONS FOR NON-PRESCRIPTION MEDICATION TO BE
FILLED OUT BY PARENT/GUARDIAN**

Medication: _____ Dosage: _____
Time to be Given: _____ Route: _____
Purpose of Medication: _____

I hereby give permission for _____ to take the above medicine at school as ordered. I understand that it is my responsibility to furnish this medication and I will personally bring it to school in its original, labeled container (instructions/dosage must match physician's order). If the prescription is changed, a new form for parent consent and a new physician's order must be completed before school staff can administer the medication. I authorize the exchange of information regarding these medicines between my child's clinic and school for the duration of the school year.

Date: _____ Signature Parent/Guardian: _____

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