Authorization For Administration of Medication At School

Student's Name: _____ Birthdate:_____

School: _____ Age: _____ Grade: _____

This portion to be completed an signed by the physician if it is necessary to dispense medication during school hours.

Name of Medication	Dosage	Method Of Admin	Time of Day To Be Taken
_____	_____	_____	_____

If PM – specify the length of time between doses _____, Reason for medication to be given during school hours:_____.

Permission to carry inhaler: Yes ☐ No ☐ Possible side effects of medication:

_____

Emergency procedure in case of serious side effects: _____

_____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above from _____to _____. There exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Such medication may be administered by medically untrained school personnel.

_____ _____/_____

Date of Signature Physician's Signature Dentist's Signature

_____ _____

Telephone Number Name (Please Print of Type)

Address: _____

This Portion of the Form is to be Completed by the Parent/Guardian

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize the school to administer the above identified medication to the above identified student in accordance with the prescription or doctor's instructions from _____ to _____ (not to exceed one school year).

Medication will be supplied to the school in the original container:

I understand and agree that because of schedule and other responsibilities, a dosage may be delayed or missed.

Permission to carry inhaler: Yes ☐ No ☐

_____ _____

Signature Date of Signature

Telephone Number: _____/_____

Home Work