



## MEDICATION ADMINISTRATION AND AUTHORIZATION FORM

Please complete both Part A and B for all medications to be given to your child. All prescription medications require a physicians' signature. Bring this completed form, along with the medication in the original container, to the school clinic. **Medication should not be sent to school with your child.** At least one dose of medication must be given at home prior to use at school.

Thank you for your cooperation in this matter.

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### **Part A**

I authorize the school representative to give my child, \_\_\_\_\_  
grade \_\_\_\_\_ the following medication. (If medicine is prescribed by his/her physician/clinic, please have them  
sign at bottom of form.) Should there be any questions, you can reach me at my home phone \_\_\_\_\_  
or my work/cell phone \_\_\_\_\_.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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### **Part B**

Please administer to \_\_\_\_\_, the following medication during the school hours:

Medication: \_\_\_\_\_

Reason: \_\_\_\_\_

Strength/Dosage: \_\_\_\_\_

Start Date: \_\_\_\_\_

End Date: \_\_\_\_\_

MD Name(print): \_\_\_\_\_ Date: \_\_\_\_\_

MD Signature: \_\_\_\_\_ Phone: \_\_\_\_\_