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.

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: ____________________________

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: __________
7/15