MEDICATION ADMINISTRATION AND AUTHORIZATION FORM

Please complete both Part A and B for all medications to be given to your child. All 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, _____, DOB_____ 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: _____

4/23