Authorization for Administration of Medication

A. To be Completed by Custodial Parent or Guardian Only.

I request that my child ____ grade _________ receive the medication prescribed below by our licensed health care provider. The medication is to be supplied by me in the properly labeled original container from the pharmacy. I understand that the supervisor/monitor as designated will be the person who will administer the medication.

Signature of Parent(s) or Guardian: ____

Address: ____

____

Primary Phone# _____________________ Secondary Phone# ______________________

Name of Back up contact (to be contacted only if primary is not available)

____

Relationship to student____

Primary Phone# _____________________ Secondary Phone # ___________________________

B. To be Completed by the Licensed Health Care Prescriber.

I request that my patient, as listed below, receive the following medication.

Name of Student___________________________________ Date of Birth ____________

Name of Medication____

Prescribed Dosage, Frequency, and Route of Administration:

____

Time to be Taken During School Hours____

Duration of Treatment____

Possible Side Effects or Adverse Reactions_______________________________________

____

Name of Licensed Provider and Title (please print) _________________________________

Signature ____

Address: ____

Phone#___________________________ Date__________________________