AUTHORIZATION FOR SCHOOL PERSONNEL TO ADMINISTER MEDICATION TO STUDENTS

Student Name: _____ Date: _____

PHYSICIAN'S STATEMENT:

Name of Prescription: _____

Amount to Administer: _____

Description (color, pill/tablet, etc.): _____
_____

Proper Dosage: _____ Time to be given: _____

By whom it is to be administered: _____

Reason for medication: _____
_____
_____

Possible side effects (if any):_____
_____

Does this prescription:
☐ Supersede previous prescriptions
☐ In addition to previous prescriptions
☐ Temporary (days)

Additional Information: _____
_____
_____

_____ _____
Physician Signature Date

PARENT'S STATEMENT / AUTHORIZATION:
We, the undersigned, do herewith delegate and authorize school personnel to administer the above named medication to _____
(student name)
as prescribed by the above named physician.

_____ _____
Parent / Guardian / Care Provider's Signature Date