Authorization for Medication Administration by School Personnel

To:					Of:				
		Princi	pal				School Name		
Student Name	e:			DOB:		_ Grade:	: Teacher:	_	
I am giving so	hool personnel	permission	to administer	medications t	o my child pe	r the follo	owing:		
Parent or Phy	rsician please co	omplete:							
Medication:	_						Non Prescription		
Dose (how much):							Prescription Rx number:		
Tablets requiring cutting should be cut by the parent before being sent to school. Liquid medication requires dosage spoons, available from your pharmacist, to be supplied by parent.							Please allow my child to self-administer this n (refer to district policy on self-medication). Requires self- agreement form to be signed by parent, school administr prescription, consent of physician. (See below)	medication	
Route: (Circle	e one)								
Ву:	Mouth	Ear	Eye	Nose	Skin	Inhal	alation		
Time to be g	iven @ school:								
Duration: Start date: End Date:									
Reason for M	edication:								
	l am responsible						ed. I understand I am responsible to notify the s lay of school. All medication left at the school w		
Parent/Guarding Signature:						Da	ate:		
	ation applies onl s necessary, be						nent or school year. This also authorizes an exc n provider.	hange of	
	·		edication for th	n writing or on ph	nose name ap	all <u>prescript</u> pears at t	otion medication). the top of this form. Instructions in the box are a	accurate.	
Physician's Name: (please print/stamp)						Address			
Physician's Signature						Phone#	Effective Date		