Authorization of Administration for

Prescription Medication

Prescription medications that Parent/Guardian request to be administered to students must be in pharmacy-prepared containers and labeled with the name of the student, name of medication, strength, dosage, frequency, name of Medical Provider and date of original prescription.

Name of Student _____ DOB _____

Address _____

Condition for which the medication is needed to be administered while at school _____

_____

Drug (name, dose, and method of administration) _____

_____

Time of Administration: _____

Medication shall be administered from _____ to _____

Side effects to be observed, if any _____

If there are side effects, plan for management _____

_____

Medical Provider's signature _____

Authorization by Parent/Guardian for administration of the above medication to be given by School Personnel:

I request that the above medication, ordered by the medical provider for my child, _____, by administered by School Personnel. I understand that I must supply the school with the prescribed medication in the original container, dispensed and properly labeled by provider or pharmacist, and will provide no more than a 45 school day supply. I understand that this medication will be destroyed if it is not picked up within one week following the termination of the order or one week following the close of the school year.

Name _____ Date _____

Signature _____ Relation to Student _____