



**AUTHORIZATION FOR PRESCRIPTION MEDICATION AT SCHOOL  
(MUST BE SIGNED BY PARENT)**

PLEASE PRINT

SCHOOL YEAR: \_\_\_\_\_

STUDENT'S NAME: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_

LEGAL GUARDIAN: \_\_\_\_\_ DAYTIME PHONE: \_\_\_\_\_

NAME OF MEDICATION: \_\_\_\_\_

REASON FOR GIVING MEDICATION AT SCHOOL (PLEASE BE SPECIFIC):

\_\_\_\_\_

AMOUNT OF MEDICATION TO BE GIVEN: \_\_\_\_\_

TIME OF DAY MEDICATION IS TO BE GIVEN AT SCHOOL: \_\_\_\_\_

DATE TO START MEDICATION: \_\_\_\_\_ DATE TO STOP MEDICATION: \_\_\_\_\_

EXPIRATION DATE OF MEDICATION: \_\_\_\_\_ POSSIBLE SIDE EFFECTS: \_\_\_\_\_

\_\_\_\_\_

PHYSICIAN: \_\_\_\_\_

PHYSICIAN'S PHONE #: \_\_\_\_\_

**PARENTS PLEASE READ CAREFULLY:**

I understand that all medication will be provided by me in the original container, clearly labeled with my child's name. I will notify the school if the medication is discontinued or the dosage has been changed. Permission is granted to the principal and/or school nurse to share this information with individuals who have responsibility for my child. The first dose will be given at home so that I can monitor adverse reactions. I give the school nurse my permission to contact the above named physician's office to request medical information concerning my child. I am responsible for replacing medication before the expiration date.

LEGAL GUARDIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_