AUTHORIZATION TO ADMINISTER MEDICATION IN SCHOOL
(To be kept confidential upon completion)

Name of Student _____ Grade_____

Diagnosis / Illness:_____

Medication :_____

Dosage:_____ Frequency:_____

Special Directions: _____

_____

Possible Side Effects:_____

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I certify that the above information regarding this student is correct and that administration of the medication to this student is necessary.

_____ _____
Printed Name of Physician Phone Number

_____
Address City State Zip

_____ _____
Signature of Prescribing Physician Date

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I / We authorize the School Nurse or in his/her absence, the Principal to administer the above medication as indicated. I / We understand and agree that the School, the School Nurse and the Principal shall not be liable for any injury to the student resulting from the administration of the medication as authorized by my/our signature below.

_____ _____
Parent's Printed Name Parent's Signature Date

_____ _____
Parent's Printed Name Parent's Signature Date