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

| Name of Student   |                     | G                                       | rade             |              |
|---|---------------------|---|------------------|--------------|
| Diagnosis / Illness:                                      |                     |   |                  |              |
| Medication :  |                     |   |                  | X.           |
|   |                     |   |                  |              |
| Dosage:   | Frequency:          |   |                  |              |
| Special Directions:                                       |                     |   | 92 X 1628 1      | 1            |
|   | Įe.                 |   |                  |              |
|   | (5)                 |   |                  |              |
| Possible Side Effects:                                    |                     |   |                  |              |
| ****  | *****               | ******                                  | ****             | •            |
|   |                     |   | 67               |              |
| I certify that the above infor                            | mation regarding    | g this student is c                     | orrect and that  | t            |
| administration of the medica                              | ation to this stude | ent is necessary.                       |                  |              |
|   |                     |   |                  |              |
| Printed Name of Physician                                 |                     | Phone Numl                              | per              |              |
|   |                     |   |                  |              |
| Addings   | City                | State                                   | Zip              | <del> </del> |
| Address   | City                | State                                   | <b>2.1</b> p     |              |
|   |                     | . D.4.                                  |                  |              |
| Signature of Prescribing Ph                               | iysician            | Date                                    |                  |              |
| *****   | ******              | ******                                  | *****            |              |
|   |                     | w .us 900                               |                  |              |
| I/We authorize the School                                 | Nurse or in his/h   | ier absence, the P                      | rincipal to aun  | inister      |
| the above medication as ind<br>School Nurse and the Princ | licated. I / We ui  | nderstand and ag<br>lighte for any init | ree that the SCI | nt           |
| resulting from the administ                               | apai shan noi be    | mable tor any inje                      | ity to the state |              |
| restiting from the authorise                              | tration of the med  | dication as author                      | rized by my/ou   |              |
| signature below.  | tration of the med  | dication as author                      | rized by my/ou   | Į.           |
| signature below.  | tration of the med  | lication as autho                       | rized by my/ou   | L            |
| signature below.  | tration of the med  | dication as author                      |                  |              |
| Parent's Printed Name                                     | tration of the med  | Hication as author  Parent's Signatu    |                  | Date         |