Genoa City Joint 2
Prescription Medication Administration Permission

To be completed by parent or guardian:

Child's Name _____ Age _____

Address _____ Telephone _____

I hereby authorize the principal of my child's school or his/her designee to dispense or administer the medication as directed on the original container labeled with me child's name.

Physician's Name _____ Telephone _____

Address _____ Date _____

Parent's Signature _____

To be completed and signed by physician:

Child's name _____

Name of medication_____

Purpose of medication _____

Time medication to be administered at school _____

Dosage _____Termination date for medication_____

Possible side effects _____

Conditions under which parent should be contacted regarding the condition or reaction of the child

receiving the medication:_____

_____

I hereby authorize the principal or his/her designee to administer the medication as directed and I will accept direct communication from the person dispensing or administering the medication.

Physicians signature _____Date _____

_____(Child's name) has my permission to carry her/his own inhaler and administer it to her/himself. I have assumed responsibility to teach her/him proper use of the inhaler.

Parent signature _____ Physician signature_____