(Form 2)

# SCHOOL CITY OF WHITING
## Authorization to Administer Prescription Medication
## Requested by Parent/Guardian

**School Year:** _____
**Grade:** _____

**Student's Name**_____ **School** NH WMS WHS **Teacher** _____

**Sections I and/or II must be completed or medication cannot be given.**

### Section I – Physician's Statement

**(If the medication is provided in the original pharmacy container, with the prescription label attached, section I is not necessary. If the medication is not so provided, this section must be filled out and signed by the prescribing physician.)**

**Medication:** _____ **Dosage:** _____ **Time:** _____
**Reason for giving:** _____

**Date** _____ **Physician's signature** _____

### Section II – Parent / Guardian's Request and Authorization

**(This section must be filled out by the parent along with either the physician's section I and/or the original pharmacy container with the prescription label or medication cannot be administered.)**

**Date:** _____ **Parent/Guardian's signature:** _____

**Home Phone:** _____ **Work Phone:** _____
**Home Address:** _____ _____ _____
Street City Zip

***I understand that the above medication must be picked up by me unless stated in writing is the person in which I give permission to pick up the medication on or before the last day of this school year.**

**ALL remaining medication will be discarded in accordance with the school's policy.**

**Signature** _____ **Date** _____

_____
Printed Name