MEDICAL AUTHORIZATION

Student's Name:_____

Grade/Teacher:_____

Name Of Medication:_____

Dosage:_____

Medication MUST be in the original container and labeled as outlined in the Student Handbook.

I hereby request the administration of the above-ordered medication to my child, who is named above, at the following time:_____AM/PM.

Dates to be Given:_____

Drug Allergies:_____

Parent/Guardian's Signature:_____ Date:_____

NOTE: This form must be completed by the parent/guardian and must be returned to the school before any medication may be administered by the school nurse or her designee.

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(For Office Use Only)

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