

AUTHORIZATION FOR MEDICATION ADMINISTRATION

Student Name:	Building:
Parent/Guardia	n: Student Grade:
As Parent/Guar school:	rdian of my child, I hereby request that my child receive the following medication at
	Medication:
	Dosage:
	Reason:
	Time Schedule:
	Comments:
I understand th	at:
> Me	edication must be in the original container.
	escription drugs must be labeled by Pharmacist and include name, dosage, amount of edication and doctor's name.
> I a	m responsible for monitoring medication supply and obtaining refills.
> Pa	rent/Guardian must hand deliver the medication to the school clinic.
	vill notify school personnel in writing of any change in dosage and/or time medication is given.
PARENT/	SIGNATURE: DATE: