MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY THE HEALTH CARE PROVIDER:

Name of Child _____Date of Birth _____

Medication/Strength _____

Dosage to be Given _____ Time to be Given _____

Route of Administration _____Diagnosis _____

Side Effects _____

Duration of Order (no longer than duration of school year_____

TO BE COMPLETED BY PARENT/GUARDIAN: I hereby give consent for the following:

_____ School staff may administer the medication to my child according to the physician's directions above.

_____. The school Director has my permission to contact the physician should there be any questions or concerns regarding this medication. I understand that this medication must be delivered to school personnel by the parent/guardian and that students are NOT to transport medication, unless it is an approved emergency medication. I understand that this medicine must be in the original, labeled container. The medication provided must match the physicians order. I hereby release the School, their agents, and employees from any and all liability that may result from my child taking this medication.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Phone: Home _____ Cell _____

Work _____

School Director Signature: _____ Date _____