

Authorization to Administer Medication During School Hours

For School Year:_____

Student Name:	Grade:
Name of Medication:	
Medication Description (e.g., tablet, drops, inhalant):	
Dosage:	
Time to be given:	
Healthcare Provider's Name:	
Healthcare Provider's Phone:	
Reason for Medication:	
Possible side effects and safety procedures:	
Parent Authorization for Medication Administration: I authorize medically unlicense to my child as stated. I understand that if the medication is still in school seven (7) day be disposed of.	
Parent/Guardian Signature:	Date:
Parent/Guardian Name Printed:	