AUTHORIZATION FOR MEDICATION ADMINISTRATION
BY SCHOOL PERSONNEL

CHILD'S NAME:	BIRTHDATE:
PARENT/GUARDIAN NAME:	ADDRESS:
HOME PHONE:	EMERGENCY PHONE:
PRESCRIBING PHYSICIAN:	PHONE:
SCHOOL/PROGRAM:	TEACHER:

ALL MEDICAITON MUST BE IN ITS NEWEST ORGINAL CONTAINER WITH THE PHARMACY LABEL (including non-prescription medication).

Medication:	☐Prescription ☐Non-Prescription
Prescription RX #:	Dosage:

***NOTE: Tablets requiring cutting must be cut by the parent before being sent to school. Liquid medication requires dosage spoons, which must be supplied by the parent. Dosage spoons are available from your pharmacist.**

ROUTE: (Circle One) BY: Mouth Ear Eye Nose Skin Inhalation

Time to be given at school:	Start Date: / / End Date: / /
Reason for Medication:	
Special Instructions:	

I do herby agree to present the above-described medication to the designated staff member of the above-named- school/program in person; in a dated, labeled container with prescription number and proper dosage. I accept the responsibility for refilling the prescription, if refillable; and accept the responsibility to notify the designated staff member of any changes in any information contained on this page. I do hereby affirm that the above school/program and its agent are held harmless from any liability, claims, judgments and costs which may be incurred in or as a result of storage and administration of the above described medication. Parents are required to pick up all unused medication by the last day of school. All medication left at the school will be discarded.

Parent/Guardian Signature_____**Date**_____

(This authorization applies only to the medication listed above and for the duration of treatment or school year).