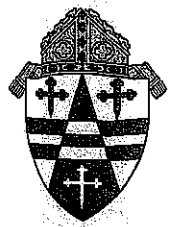


**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL**



Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_

**THIS PORTION TO BE COMPLETED BY THE PHYSICIAN/DENTIST**

<u>Name of Medication</u>	<u>Dosage</u>	<u>Methods of Administration</u>	<u>Time of Day to Be Taken</u>
_____	_____	_____	_____

If given prn specify the length of time between doses \_\_\_\_\_

Inhalers: \_\_\_\_\_  
Indicate if student must carry on his/her person

Epi-Pen: \_\_\_\_\_  
Indicate if student must carry on his/her person

Possible side effects of medication \_\_\_\_\_

Emergency procedure in case of serious side effects \_\_\_\_\_

I request and authorize that the above-named student be administered the above- identified medication in accordance with the instructions indicated above from \_\_\_\_\_ to \_\_\_\_\_ (not to exceed current school year) as there exists a valid health reason, which makes administration of the medication advisable during school hours.

\_\_\_\_\_  
Date of Signature Physician/Dentist Signature

\_\_\_\_\_  
Telephone Number: Name: \_\_\_\_\_  
Print or Type

**Please Note: If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.**

**THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN**

I request/authorize the school to administer medication to the above identified student in accordance with the doctor's instructions for the period from \_\_\_\_\_ to \_\_\_\_\_ (not to exceed current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner.

Permission to carry inhaler and/or Epi-Pen (please circle)

\_\_\_\_\_  
Date of Signature Parent/Guardian Signature

\_\_\_\_\_  
Telephone number: \_\_\_\_\_ (home) \_\_\_\_\_ (work)