



MEDICATION ADMINISTRATION AUTHORIZATION

For the protection of your child and the Academy, we ask that the following procedures be followed if you would like your son/ daughter to take medicine while at school.

1. The medication must be in the original container.
2. The authorization (below) must accompany the medication.

Authorization for Medication Administration

Student Name: _____ Birthdate: _____ Grade: _____

Parent/Guardian Name(s): _____

Home Phone: _____ Work Phone: _____

1. Physician's name & phone #: _____
2. Name of medication: _____
3. How much medication should be given: _____
4. How often is medication to be given: _____
5. Reason medication is to be given: _____
6. Possible reaction to medication (symptoms, side effects, etc.)

Physician's Signature: _____ Date: _____
(Required if medication exceeds normal dose range.)

Parent/Guardian Request/Approval:

I certify that I am the parent or guardian of the above named student. I request and authorize school personnel to dispense the above named medication in accordance with the prescription, doctor's orders or as indicated above.

Parent/Guardian Signature: _____ Date: _____