AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

***Medications must be brought to school in the original, properly labeled container.**

Parent/Guardian Authorization

Name of student: ______________________ **Date:** ________________

Condition for which drug is being administered: ____________________________

Drug name: ________________________ **Dose:** __________________________

Time of Administration: ______________ **Frequency:** ______________________

Relevant side effects: ____

I hereby request that the above ordered medication be administered by school personnel.

Parent/Guardian Signature: ________________________ **Date:** ____________