Authorization For Administering Medication

I hereby give my permission for the nurse or school personnel to administer medication during the school day to my child, _____.

_____
Signature of parent/guardian

_____
Date

Send medications on field trips? ☐ Yes ☐ No

Give medications on half days? ☐ Yes ☐ No

Physician's Instructions

Name of Child: _____

Date of Order: _____

Diagnosis: _____

Name of Medication: _____

Dosage: _____

Time to be given during school: _____

This medication:

_____ Has an end date of: _____

_____ Is for the entire school year.

_____ Is PRN.

_____ Morning dose may be given at school if forgotten at home.

Morning dose is _____

Can a reaction be expected? _____ If so, describe: _____

_____

_____

_____

_____ _____ _____

Signature of Physician Date Phone