Authorization for the Administration of Medication
by School Personnel for K-12 Students

Please fill out this form if your child is on medication that he/she will receive at school.

Physician’s written order and parent/guardian authorization are required for administration of medication.

Physician—Please Complete the Following:

Name of Student: ___________________________ DOB: ___________________________

Last   First   Middle I.

Name of Medication: ___________________________ Condition Prescribed For: ___________________________

Dosage: ___________________________ Times of Administration: ___________________________

Possible Side Effects: ___________________________

Treatment for Side Effects: ___________________________

Date of Order: ___________________________ Duration of Order: ___________________________

Signature: ___________________________ Phone Number: ___________________________

Physician          Physician’s Phone Number

Parent or Legal Guardian—Please Complete the Following:

I request that the above medication be administered to my child at school as ordered by the physician.

Signature: ___________________________ Phone Number: ___________________________ / ___________________________

Parent/Guardian          Home          Work

*Parents will be contacted by the nurse regarding the appropriate disposal or return of any unused medication.*