# MEDICATION ADMINISTRATION AUTHORIZATION FORM

***This form must be completed by the parent/guardian in order for the school authorized personnel to administer the required medication. A new form must be completed when there is a change in the dose or time of administration.***

- All medications must be in the original labeled container.
- An adult will bring the medication to school.

**Name of Student:** ___________________________________ **Grade Level:** __________

**Medication Name:** __________________________________ **Dose:** ________________________

__________________________________ ________________________

**Method of Administration:** Mouth: ______ inhaler: _______ other (specify): _____________

**Time to be Given:** ______________________________

**Possible Side Effects:** ____________________________________________________________

**Reason for Medication:** __________________________________________________________

**Beginning date of Administration:** ___________________ **Ending date:** ___________________

***I authorize the school nurse and/or other authorized personnel to administer the medication as specified above.***

Signature of parent/guardian: _____________________________________

Home phone: ___________________ Mobile phone: _____________________

Date: _________________

*This form has been checked & verified by the undersigned*

School Nurse: ____________________________________ Date: __________________