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: _____

mathafnurse@wellspring.edu.lb Mathaf

cccnurse@wellspring.edu.lb CCC