



AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL

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Student Name: _____

Birth Date: _____

School: _____

Grade: _____

THIS PORTION TO BE COMPLETED BY THE PHYSICIAN/DENTIST

Name of Medication

Dosage

Methods of Administration

Time of Day to Be Taken

If given prn specify the length of time between doses _____

Inhalers: _____

Indicate if student must carry on his/her person

Possible side effects of medication _____

Emergency procedure in case of serious side effects _____

I request and authorize that the above-named student be administered the above- identified oral medication in accordance with the instructions indicated above from _____ to _____ (not to exceed current school year) as there exists a valid health reason, which makes administration of the medication advisable during school hours.

_____ Date of Signature

_____ Physician/Dentist Signature

Telephone Number: _____

Name: _____

Print or Type

Please Note: If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request/authorize the school to administer medication to the above identified student in accordance with the doctor's instructions for the period from _____ to _____ (not to exceed current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner.

Permission to carry inhaler

_____ Date of Signature

_____ Parent/Guardian Signature

Telephone number: _____ (home) _____ (work)