MEDICATION AUTHORIZATION FORM

I request the enclosed medication, in the original container be administered to my child and shall release school personnel from all liability.

Name of Student____________________ DOB: _________ Grade______________

Name of Medication: ____

Dosage and frequency: ____

Diagnosis/Purpose: ____

Parent's Signature: ____ Date: ___________

Primary Phone Number: ____

Secondary Phone Number: ____

____

TO BE COMPLETED BY THE PHYSICIAN ONLY FOR ALL PRESCRIPTION AND OVER THE COUNTER MEDICATIONS: The **only exception** is Acetaminophen/Ibuprofen which can be administered with *signed Medical release form*

Name of Medication:

____

Dosage, frequency, duration:

____

Diagnosis/Purpose:

____

Reason that medication must be given during the school day:

____

Physician's Signature : Physician's Name (print):
Phone Number:
Date:

____

____

Physician's Stamp

THIS FORM IS ONLY VALID FOR THE CURRENT SCHOOL YEAR