MEDICATION:
ADMINISTERING TO STUDENTS

AUTHORIZATION

Name _____ Grade _____

Teacher _____ School _____

Time to be administered _____a.m. _____ p.m.

Date from _____to _____

TO PARENT/GUARDIAN/INDIVIDUAL ASSUMING PERMANENT CARE AND CUSTODY: Is the medication that you wish administered to your child prescription medicine? _____. If so, please provide the name of the medical doctor who prescribed the medication: _____

Is the child's disability or illness such that the medication must be self-administered by the child (asthma, etc.)? _____. If so, the student's medical doctor should include a statement to that effect in the child's prescription. The parent or guardian must provide a written statement from the physician treating the student that the student has asthma and is capable of, and has been instructed in the proper method of, self-administration of medication.

Prescription medication must be furnished by the parent or guardian with the original label prepared and attached by a pharmacist. The label must reflect the name, strength, and dosage of the medication and whether or not the medication may be self-administered by a minor. Non-prescription medication must be in the original container that must reflect the name and strength of the medication.

This form must be signed by the parent/guardian of the child named herein. The signature of the prescribing physician may be required at the discretion of the medication administrator.

_____ _____

Signature of Parent/Guardian/Individual Assuming Permanent Care and Custody — Date

_____ _____

Physician's Signature (required for self-administration of medication) — Date