Medication Authorization Form

Name of Student:		Age:
Non-prescription medication must be in the original container with the label intact. Prescription medication must be in a container labeled by the pharmacist or prescriber.		
Parent/Guardian:		
I hereby request and authorize the trained	school employe	ee to administer the following
Medication(s):		
Dosage:Times to be	e Administered:	l:
Dosage:Times to be Administered: Special instructions (if any): until: until: This authorization is effective from: until: (Start date)		
(St	art date)	(End date)
Parent/Guardian Signature		Date
l,	certify	y that it is medically necessary for the
(Name of Physician)		,, ,
medication(s) listed below to be admini	istered to:	
		(Child's Name)
Medication(s):		
Dosage:Times to be	e Administered:	d:
Special instructions (if any):		
		until:
·	cart date)	(End date)
Physician's Signature		Date
Physician's Phone:		