MEDICATION AUTHORIZATION FORM

All prescriptions must be in the original, labeled container and stored in the school office under lock and key.

The following information must be completed before the medicine is given.

NAME: _____ GRADE: _____

PARENT/GUARDIAN: _____

HOME PHONE: _____ WORK PHONE: _____

NAME OF PRESCRIPTION: _____

AMOUNT OF DOSAGE: _____

TIMES TO BE GIVEN: _____

PRESCRIBING PHYSICIAN: _____

I hereby authorize _____
(name of school)

to dispense _____ as directed above.
(name of prescription)

Signed: _____

Date: _____

A separate Medication Authorization Form must be completed for each different medication.