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 employee to administer the following

Medication(s): ____

Dosage: __________________Times to be Administered: ___________________________________

Special instructions (if any):____

____

This authorization is effective from: ____________________ until: ___________________________
(Start date) (End date)

Parent/Guardian Signature ___________________________________ Date ____________________

Physician Authorization: Physician authorization is needed for the following:

Long-term medication authorization, Any change in medication directions, If administration does not match labeled directions, or Self-carry/Self-administrated medication

I, _____________________________________ certify that it is medically necessary for the
(Name of Physician)

medication(s) listed below to be administered to: ______________________________________
(Child's Name)

Medication(s): ____

Dosage: __________________Times to be Administered: ___________________________________

Special instructions (if any):____

____

This authorization is effective from: ____________________ until: ___________________________
(Start date) (End date)

Physician's Signature ___________________________________ Date ____________________

Physician's Phone: _____________________________________