



AUTHORIZATION TO ADMINISTER MEDICINE IN SCHOOL

(To be kept confidential upon completion)

NAME OF STUDENT _____ GRADE _____

DIAGNOSIS/ILLNESS _____

MEDICATION _____

DOSAGE _____ FREQUENCY _____

SPECIAL DIRECTIONS _____

POSSIBLE SIDE EFFECTS _____

I certify that the above information regarding this student is correct and that administration of the medication to this student is necessary.

Signature of Prescribing Physician

Date

Address

Phone

I/We authorize the school nurse, or in his/her absence, the principal, to administer the above medication as indicated. I/We understand and agree that the school, the school nurse, and the school principal shall not be liable for any injury to the student resulting from the administration of the medication as authorized by my signature below.

Signature of Parent/Guardian

Date

Signature of Principal

Date