MEDICATION AUTHORIZATION

Name of Student ____ **Grade** ___________

SCHOOL ADMINISTERED:

Medical Condition	Medicine Name	Dose # Tablets	Time(s) Frequency	Strength Mg/ml	Start Date	Stop Date

_______________________________________ _______________________________________

Print Name of Physician/Licensed Prescriber Signature of Physician/Licensed Prescriber

_______________________________________ _______________________________________

Clinic Name/Location Phone Number

☐ Please sign below if you want the ***school and its personnel to administer this medication***. A Physician or Licensed Prescriber must list the medical information above and authorize its use with their signature and the name of the clinic. We will not give medication without proper authorization from you. Page 2 explains school policy regarding administration of medication at school. I release the school and its personnel from liability in the event of any reactions resulting from this medication.

__________ ________________________________ ______________________________

(Date) (Parent Signature) (Student Signature)

SELF-ADMINISTERED:

Medical Condition	Medicine Name	Dose # Tablets	Time(s) Frequency	Strength Mg/ml	Start Date	Stop Date

☐ I request that my high school child ***self-administer over-the-counter medication*** listed above, following the guidelines on Page 2. My child will keep this medication in his/her locker in a container labeled by pharmacy/physician. The medication is limited to one day's self administration. All rules as outlined on Page 2 are understood and will be followed. I release the school and its personnel from liability in the event of any reactions resulting from this medicine.

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(Date) (Parent Signature) (Student Signature)