Authorization for the Administration of Medication

(including over the counter medicine and/or pain relievers)

Name of Student:_____ Date of Birth: _____

Medication Name: _____

Specific Instructions for Medication Administration:

Dosage: _____ Time of Administration: _____

Medication shall be administered: Start Date: ____ / ____ / ____

End Date: ____ / ____ / ____

Relevant side effects of medication: _____

Explain any allergies, reaction to/negative interaction with food: _____

Storage requirements for medication: _____

Special instructions (if any) for administration: _____

☐ I have administered at least one dose of this medication to my child without adverse effects.

If Side Effects Occur, the Plan of Management should be: _____

_____

I request that school personnel administer the medication to my child as described and directed above. I will inform school personnel if medication has been given to my child prior to coming to school, which could affect a dosage to be given at school. I absolve school personnel and the school district from liability stemming from adverse reaction and all other adverse effects, which may occur because of administering of such medication described above.

If any revisions in the request occur, a written statement (including date & signature) must be submitted to the school.

_____

Parent/Guardian Signature Date