**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL**

Student Name: _____ Birth Date: _____

School: _____ Grade: _____

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**THIS PORTION TO BE COMPLETED BY THE PHYSICIAN/DENTIST**

| Name of Medication | Dosage | Methods of Administration | Time of Day to Be Taken |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

If given prn specify the length of time between doses _____

Inhalers: _____
Indicate if student must carry on his/her person

Epi-Pen: _____
Indicate if student must carry on his/her person

Possible side effects of medication _____

Emergency procedure in case of serious side effects _____

☐ I request and authorize that the above-named student be administered the above- identified medication in accordance with the instructions indicated above from _____ to _____ (not to exceed current school year) as there exists a valid health reason, which makes administration of the medication advisable during school hours.

_____ _____
Date of Signature Physician/Dentist Signature

Telephone Number: _____ Name: _____
Print or Type

**Please Note: If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.**

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**THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN**

I request/authorize the school to administer medication to the above identified student in accordance with the doctor's instructions for the period from _____to _____ (not to exceed current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner.

Permission to carry inhaler and/or Epi-Pen (please circle)

_____ _____
Date of Signature Parent/Guardian Signature

Telephone number: _____ (home) _____(work)