AUTHORIZATION TO ADMINISTER MEDICATION IN SCHOOL

(To be CONFIDENTIAL upon completion)

NAME OF STUDENT: ______________________ GRADE: _________

DIAGNOSIS / ILLNESS: ____

MEDICATION: ____

DOSAGE: ___________________________ FREQUENCY: _________

SPECIAL DIRECTIONS: _______________________________________

POSSIBLE SIDE EFFECTS: ____________________________________

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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

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I / We authorize the school nurse or, in her absence, the principal to administer the above medication as indicated. I / We understand and agree that the school, the school nurse and 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

____

Name of Parent / Guardian (PRINT)

____

Date

APPENDIX “A”