AUTHORIZATION TO ADMINISTER MEDICATION

This form must be completed in it's entirety prior to the administration of any medication at school.

ORDERS FROM HEALTH CARE PROVIDER AUTHORIZED TO PRESCRIBE MEDICATION

The following medication will be required to be given during the school day
8:00 a.m. to 2:00 p.m.

Student's name _____

Medication _____

Strength _____

Dose to be administered _____

Time(s) to be given _____

Specific directions / side effects: _____

_____

_____ ___/___/___
Signature of Authorized Prescriber Date