AUTHORIZATION TO ADMINISTER MEDICINE IN SCHOOL

(To be kept confidential upon completion)

NAME OF STUDENT_____GRADE_____

DIAGNOSIS/ILLNESS_____

MEDICATION_____

DOSAGE_____FREQUENCY_____

SPECIAL DIRECTIONS_____

POSSIBLE SIDE EFFECTS_____

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

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

_____

Signature of Principal Date