Administration of Medication at School

(Parent Authorization)

We (I), the undersigned, who are the parents/guardians of:

Child's Name: _____

Birthdate: _____

request that the following medications(s) be administered to our child as per the schedule outlined:

_____

_____

_____

Name of Medication: _____

Dose: _____

Time/Frequency: _____

Prescribing Doctor: _____

Allergies:_____

_____

_____ _____

Name of Parent/Guardian (Please Print) Signature(s)

Phone: _____ _____ _____

Home Work Cell

In case of emergency contact _____

Phone: _____ _____ _____

Home Work Cell

Date: _____