AUTHORIZATION TO ADMINISTER MEDICATION 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 the student is necessary.

______________________________ __________________

Signature of Prescribing Physician Date

______________________________ __________________

Address Phone Number

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I/We authorize the nurse or, in his/her absence, the Principal or staff member to administer the above medication as indicated. I/We understand and agree that the Academy, the Nurse, and the Principal or staff member shall not be liable for any injury to the student resulting from the administration of the medication as authorized by my signature below.

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Signature of Parent/Guardian

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Signature of Parent/Guardian

____

Date