AUTHORIZATION FOR ADMINISTERING MEDICATION BY SCHOOL PERSONNEL

ALL MEDICATIONS MUST BE IN ORIGINAL CONTAINERS BY STATE LAW

INISTERING MEDICATION BY SCHOOL PERSONNEL

I hereby authorize school personnel to administer medication as indicated

Name_____Grade_____

Name of Medication_____

Rx Number_____

Directions_____

Time to be given at school_____ Hours when medication at home_____

Date Medication Received_____

_____

_____

I understand that my signature attached, herewith, relives the school personnel of any and all liability related to the administration of the prescribed medication My signature also gives permission for my student to take home any remaining medication at the end of the school year. If I do not wish my student to pickup his medication, I am signing the area indicated.

DATE_____ SIGNATURE_____

My child may NOT take their medication home at the end of the year_____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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