AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL

Student Name: _____ Birthdate: _____

School: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY THE PHYSICIAN/DENTIST

Name of Medication	Dosage	Methods of Administration	Time of day taken
_____	_____	_____	_____
_____	_____	_____	_____

If given prn specify the length of time between doses _____

Inhalers: _____
Indicate if student must carry on their person

Student is capable to self-administration of medication ____ Yes ____ No

Possible side effects of medication _____

Emergency procedure in case of serious side effects _____

I request and authorize that the above-named student be administered the above-identified oral medication in accordance with the instructions indicated above from _____ to _____ (not to exceed current school year) as there exists a valid health reason which makes administration of the medication advisable during school hours.

_____ _____
Date of Signature Physician/Dentist Signature

Phone: _____ _____
Print or Type Name

Please note: If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request/authorize the school to administer medication to the above identified student in accordance with the doctor/dentist's instructions for the period from _____ to _____ (not to exceed current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner.

Permission to carry inhaler ____ Yes ____ No
Permission to self-administer medication ____ Yes ____ No

_____ _____
Date of Signature Phone Parent/Guardian Signature