Date: [Insert Date]

To: School Nurse / Health Office Administration
School Name: [Insert School Name]

Medication Administration Authorization Form

Student Information:

Student Name: [Insert Student Name]
Date of Birth: [Insert DOB]
Grade/Class: [Insert Grade]

Medication Details:

- Name of Medication: [Insert Medication Name]
- Dosage: [Insert Dosage, e.g., 5mg]
- Route: [Insert Route, e.g., Oral, Topical]
- Time/Frequency: [Insert Time of Day or Frequency]
- Reason for Medication: [Insert Condition]
- Start Date: [Insert Date]
- End Date: [Insert Date or "End of School Year"]

Authorization:

I, the undersigned, request and authorize the school nurse or designated school personnel to administer the medication listed above to my child. I confirm that the medication is provided in its original pharmacy container, clearly labeled with the student's name and instructions.

I understand that it is my responsibility to provide the medication and to notify the school immediately of any changes in the prescription or the child's health status.

Emergency Contact Information:

Parent/Guardian Name: [Insert Name]
Phone Number: [Insert Phone Number]
Physician Name: [Insert Doctor Name]
Physician Phone: [Insert Doctor Phone]

_____
Parent/Guardian Signature

Date Signed