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 Prescibing Physician) (Date)

_____ _____

(Address) (Telephone)

I/We authorize the School Nurses, in his/her absence, the Volunteer Registered Nurse to administer the above medication as indicated. I/We understand and agree that the School, the School Nurse, and the Volunteer Nurse shall not be liable for any injury to the student resulting from the administration of the medication authorized by my signature below.

_____

(Signature of Parent/Guardian)

_____

(Signature of Parent/Guardian)

_____

(Date)