Medication Authorization Form

Student Name ____

Medication prescribed: ____
For: ____

Administration method: (oral, topical, etc) _________________________
Frequency of administration: ____________________________________
Beginning date of medication: _______________ End date: ___________

*Medication must be kept in its original containers!

I give permission for ______________________________ to administer the above medication to my child as explained above.

Parent signature ____
Printed name ________________________________ Date ____________

Date	Time	Medication	Amount	Given by