**PARENT/GUARDIAN’S AUTHORIZATION FOR**

**ADMINISTRATION OF MEDICATION IN SCHOOL**

*A parent/guardian must complete this form.*

Name of Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade: \_\_\_\_\_\_\_ Building: ZIC ES / MS / PBL or MLK HS Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request that my child, as listed above, receive the following as prescribed by my licensed health care provider:

|  |  |  |
| --- | --- | --- |
| Name of Medication | Dosage | Time Taken at School |
| 1.) |   |   |
| 2.) |   |   |
| 3.) |   |   |
| 4.) |   |   |
| 5.) |   |   |

The medication is to be furnished by me, in the properly labeled, original container(s) from the pharmacy; plus, an empty, original labeled container to be used for class trips. I understand that the School Nurse or other designated person(s) in case of the absence of the School Nurse will administer the medication(s).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Parent/Guardian Signature Date*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Name of Licensed Prescriber and Title* (Please Print)

Phone: (\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_ Other: (\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_

My child, as listed above, is not currently taking any medication.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Parent/Guardian Signature Date*