Authorization For Administration of Medication at School

Name of Student _____ Birthdate _____

Grade _____

Medical Condition	Medication	Strength	Dose	Time	Possible Side Effects

Please sign below for school personnel to administer nonprescription or prescribed medication to the student listed on this form:

Parent/Guardian Signature _____

Physician's Signature _____

Start Date: _____ Stop Date: _____

ALL MEDICATIONS (OVER THE COUNTER DRUGS INCLUDED) REQUIRE A PHYSICIAN'S SIGNATURE.

_____ _____

Print or Type Name of Physician/Licensed Prescriber

Physician's/Licensed Prescriber's Signature

_____ _____

Clinic Address

Phone Number

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by the student's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
3. I will notify the school of any change in medication(s), example – dosage change, medication is discontinued, etc.
4. I give permission for the office staff to communicate with the student's teachers about the student's health condition(s) and the action of the medication(s).
5. I give permission for the MSA nurse to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).
6. I give permission for the medication(s) to be given by designated personnel as delegated by MSA's nurse.
7. Only FDA approved medications will be administered to a student.

Parent/Guardian Signature _____ Date _____