Desoto County Schools

Authorization to Administer Medication

Student:_______________________________ School: __________________________________

All medications authorized to be administered at school must be in the original pharmacy labeled container. Please name and briefly describe the medication below:

Medication:____

Purpose:____

Dosage and time to be given: ____

Describe any known adverse reactions/special precautions that school personnel should be aware of:____

____

***Note: The first dose of any medication should be given at home in case there is an allergic reaction.**

I request and authorize designated personnel of the Desoto County School District to administer the above described medication.

____ Date: __________________________
(Parent/Guardian Signature)

Daytime telephone number: ____

Emergency name and telephone number: ____

Doctor name and telephone number: ____

Doctor signature required for over-the-counter medication if requested by the principal or if a school nurse is administering the medication.

____ **Date:** ____________________________
(*Physician Signature)*

Physician Office Stamp:

See Board Policy JGCDC for medication guidelines