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