## **Authorization To Give Medication**

☐ This n	nedication is for	1-3 days only Start Date: _	End Date:
 ☐ This p	rescription med	icine will be given daily un	til further notice.
This C	over the Counter	medicine will be kept at s	chool longer than 3 days
(Requ	uires a physician	's signature)	
Prescription medicati	ions must be in the	•	ne child's parent(s) or legal guardian. abel as proof of Healthcare Provider
I hereby request scho	ool personnel to give	e the medication described belo	ow to my child:
Student's Name			
	First	Middle	Last
Date of Birth		Student's Teacher	(K-6 <sup>th</sup> grade only
•	•	peen prescribed for my child by:	
		Fax #	
		giving my child this medicine:	
Name of Medicine:_		· · · · · · · · · · · · · · · · · · ·	
Dosage:			
Possible reactions or	side effects (list):_		<del>-</del>
Note: Over the count	er medications sho	ould be in the original container,	dated upon receipt, and given no
more than three (3) o	consecutive days wi	ithout written permission from	Healthcare Provider.
Physician's Signature	2:	Da	te:
expressly waive any l understand that I hav medication to enable	iability on behalf of ye the ultimate resp the request for med communication be	the school as a result of admini consibility for providing the scho dication be followed. My signat	school according to school policy and stration of the above medication. I ol with an adequate supply of ture will give permission for exchange and the school nurse regarding my
Signature of Parent o	or Legal Guardian		Date:
Home Phone:		Work Phone:	
<b>.</b>			. Ni salas s
Emergency Contact N	vame:	Phone	e Number: