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