AUTHORIZATION TO ADMINISTER MEDICATION IN SCHOOL

Name of child: ____ Grade: _________ DOB: ______________

Name of medication: ____

Dosage and Frequency :____

Conditions or symptoms medication is being given for :

____

____

Special instructions or restrictions: ____

____

Possible side effects: ____

____

I authorize the school nurse or another school employee trained by the nurse, to administer the above medication to my child during regular school hours, and other times when my child is participating in a school related event, according to the frequency and directions indicated above. I understand that the school nurse, and other school employees shall incur no liability as a result of any injury arising from the administration of medication; that I will indemnify and hold harmless the school nurse and other school employees against any claim arising from the administration to my child.

Parent's Signature: ____ Date:____________________

Prescriber's Signature:____Date:_____________________

Name of Licensed Prescriber and Title (Print or Stamp): ____

Address:____

Phone:____