

**MEDICATION:  
ADMINISTERING TO STUDENTS  
AUTHORIZATION**

Name \_\_\_\_\_ Grade \_\_\_\_\_

Teacher \_\_\_\_\_ School \_\_\_\_\_

Time to be administered \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.

Date from \_\_\_\_\_ to \_\_\_\_\_

TO PARENT/GUARDIAN/INDIVIDUAL ASSUMING PERMANENT CARE AND CUSTODY: Is the medication that you wish administered to your child prescription medicine? \_\_\_\_\_. If so, please provide the name of the medical doctor who prescribed the medication: \_\_\_\_\_

Is the child's disability or illness such that the medication must be self-administered by the child (asthma, etc.)? \_\_\_\_\_. If so, the student's medical doctor should include a statement to that effect in the child's prescription. The parent or guardian must provide a written statement from the physician treating the student that the student has asthma and is capable of, and has been instructed in the proper method of, self-administration of medication.

Prescription medication must be furnished by the parent or guardian with the original label prepared and attached by a pharmacist. The label must reflect the name, strength, and dosage of the medication and whether or not the medication may be self-administered by a minor. Non-prescription medication must be in the original container that must reflect the name and strength of the medication.

This form must be signed by the parent/guardian of the child named herein. The signature of the prescribing physician may be required at the discretion of the medication administrator.

\_\_\_\_\_  
Signature of Parent/Guardian/Individual Assuming  
Permanent Care and Custody

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Signature  
(required for self-administration of medication)

\_\_\_\_\_  
Date