Marshall County Central

Authorization for Administration of Medication

School Year: ______________________________

Student Name:	DOB:
Parent(s)/Guardian:	
Address:	
Phone # (please specify)	

MUST BE COMPLETED BY PRESCRIBING PROVIDER

Medication Name	
Dosage needed in School	
Time to be given in School	
Diagnosis	**If Asthma, please include asthma action plan.**
Possible Side Effects	
Physician Contact Info	
Student should self-carry medication in bag-pack or with them: YES / NO **If Yes, please fill out the Self-Administration of Medications form.**	
Student should self-administer medication: YES / NO **If Yes, please fill out the Self-Administration of Medications form.**	

Signature of Provider: ____ Date: ____________

I request and give my permission for school personnel to administer the above medication to my child. I understand it is my responsibility to refill medication when notified, and that any changes in dosage or new medications require a new provider's signature. Discontinuations require a note from a parent. If my child is to self-administer this medication, additional forms will need to be filled out. I understand the school is not liable for any adverse reactions.

Signature of Parent/Guardian: ____ Date: ___________

PLEASE RETURN COMPLETED FORM TO THE SCHOOL NURSE

Reviewed/Date ______________