AUTHORIZATION FOR SCHOOL PERSONNEL TO ADMINISTER MEDICATION TO STUDENTS

Student Name: ___________________________ Date: ____________

PHYSICIAN’S STATEMENT:

Name of Prescription: ___________________________________________

Amount to Administer: __________________________________________

Description (color, pill/tablet, etc.): ______________________________________

Proper Dosage: _______________ Time to be given: _______________

By whom it is to be administered: _______________________________________

Reason for medication: _____________________________________________

Possible side effects (if any): _________________________________________

Does this prescription:

☐ Supersede previous prescriptions
☐ In addition to previous prescriptions
☐ Temporary ( _____ days)

Additional Information: _____________________________________________

______________________________________ Date

Physician Signature

PARENT’S STATEMENT / AUTHORIZATION:

We, the undersigned, do herewith delegate and authorize school personnel to administer
the above named medication to _________________________________________ (student name)
as prescribed by the above named physician.

____________________ Date

Parent / Guardian / Care Provider’s Signature

SpE-22
8/2016