

Stephen - Argyle Central

Authorization for Administration of Medication

School Year: _____

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

MUST BE COMPLETED BY PERSCRIBING 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 _____