

AUTHORIZATION TO ADMINISTER PRESCRIPTIVE MEDICATION**PHYSICIAN'S STATEMENT**

I have prescribed the medication indicated below for: \_\_\_\_\_  
 and do hereby authorize the nurse or principal, or their designee (i.e. secretary), of \_\_\_\_\_  
 \_\_\_\_\_ School, to administer the medication as indicated.

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Physician's Signature

\_\_\_\_\_  
 Physician's Name (printed)

\_\_\_\_\_  
 Physician's Phone Number

**PARENT'S AUTHORIZATION**

I do hereby authorize the person(s) designated by the above physician to administer this medication for  
 my child, \_\_\_\_\_ as prescribed above. I further  
 understand that I will be responsible for supplying this medication to the school in the original pharmacy  
 labeled container.

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Parent/Guardian Signature

\_\_\_\_\_  
 Telephone

\_\_\_\_\_  
 Address

**PLEASE NOTE:** The Physician's Statement and the Parent's Authorization are valid only for the  
 current school year. **Unless the authorization and the statement are  
 renewed, the medication cannot be given to the student.**

**TO BE PLACED IN LOCKED STORAGE AREA WITH THE PRESCRIPTION MEDICATION**