



Medication Authorization for a Student at School

Please Check: Prescription Non-Prescription

Name of Student: Birth Date:

In order to keep this student in optimum health and to help maintain maximum school performance, it is necessary that medication be given during school hours.

Prescribing Health Care Clinician: Phone #:

Medication: Diagnosis:

Dosage and Frequency (Amount to be given and time):

Expected dates for administration:

Possible Adverse Reactions that should be reported to health care clinician:

Check here if serious reaction can occur if medication is not given exactly as prescribed.

Check here if serious reaction can occur even when medication is administered properly.

Actions to be taken if adverse reaction occurs:

Special Handling Instructions:

NOTE: The health care clinician may use another format (computer printout, letter, etc.) to authorize administration of the medication. All information requested above must be provided.

SIGNATURE OF HEALTH CARE CLINICIAN

DATE

No injection will be given except in extreme emergency, such as allergy to wasp, bee stings, peanuts.



Parent's Permission

I hereby give my permission for my child (named above) to receive medication during school hours. I understand that the school undertakes no responsibility for the administration of the medication. This medication has been prescribed by a licensed physician or other health care clinician. I hereby release High Point Friends School and their agents and employees from any and all liability that may result from my child taking the prescribed medication.

Signature of Parent or Guardian

Phone #

DATE