MEDICINE AUTHORIZATION FORM
(This form must be replaced EVERY school year and for summer camps.)

Dear Parents/Guardians:

We can only administer medications that are prescribed by a physician. Medication must be brought to school in the original, labeled prescription container and/or box by a parent or guardian. This form and the prescribed medication cannot be accepted without the prescribing physician’s signature below.

Student Name: ________________________________

Teacher/Grade: ________________________________

Name of Medication: ________________________________

Time and amount student will receive medication at home: ________________________________

Time and amount student will receive medication at school: ________________________________

Refrigeration required? Yes No

Date of Prescriptions: ___________ Amount left at school: ___________

Medication directions (as on label): ______________________________________

____________________________________________________

Duration and expiration of prescription: ______________________________________

Parent/Guardian Signature __________________ Date __________

Printed Name __________________ Daytime Phone Number __________________

Name of physician who prescribed medication: ________________________________

Physician Signature __________________ Date __________

For Office Use Only:

Date Prescription Received for Current School Year or Summer Camp: __________________

Prescription Distributed to Teacher(s):

Date and Signature(s)