

**AUTHORIZATION TO ADMINISTER MEDICATION  
BY SCHOOL PERSONNEL**

\* Please complete both parts \*

**I. For Parent:**

I, \_\_\_\_\_ request that the school nurse (or other authorized personnel \*)  
*(name of parent / guardian)*  
administer to \_\_\_\_\_ the medication by \_\_\_\_\_.  
*(name of pupil)* *(name of physician)*  
\_\_\_\_\_  
*(parent / guardian's signature)* *(date signed)* *(phone number)*

**II. For Family Physician:**

This is to certify that \_\_\_\_\_ is being attended and treated by me. It is  
*(name of pupil)*  
essential that he / she be given the following medication, in the dose indicated, during school hours for the treatment  
of \_\_\_\_\_.  
*(please specify)*

**Medication:**

a. Prescription: \_\_\_\_\_  
*(Name of medication (or other identification))*

Over-the-counter: \_\_\_\_\_  
*(Name of medication (or generic equivalent))*

b. Dosage: \_\_\_\_\_

c. Possible side effects: \_\_\_\_\_

d. Frequency: \_\_\_\_\_

e. Length of time to be given *(check one)*: \_\_\_\_\_ Indefinitely  
\_\_\_\_\_ Discontinue on \_\_\_\_\_  
*(date)*

\_\_\_\_\_  
*(physician)* *(physician's signature)*

\_\_\_\_\_  
*(street address)* *(date signed)*

\_\_\_\_\_  
*(city, state, zip)* *(phone number)*

(\*) Medications are administered by school nurses. However, medications which require professional nursing skill or judgement may be administered by an administrator, teacher or support personnel with training from the nurse if the pupil is medically self-directed.

Note: It is the parent / guardian's responsibility to see that the school nurse receives this authorization. Medications cannot be administered without authorization.