East Buchanan C-1 School District

Parent Authorization for Medication Administration

Student's Information

Name:_____ Age:_____ Date of Birth:_____

Grade:_____ Teacher:_____

Medication/Prescription Information

☐ Prescription Medication ☐ Over-the-counter Medication Provided by Parent/Guardian

Has the student been given the first dose of this medication? Yes _____ No_____

Name of Medication:_____

Reason for Medication:_____

Describe the schedule and dose to be given at school:_____

If "as needed," please indicate the maximum dosage per day:_____

Are there restrictions and/or important side effects:_____

_____

Storage requirements: None_____ Refrigerate_____ Other:_____

Physician's Information

Physician's Name:_____

Phone Number:_____ Fax:_____

Parental Permission

I give permission for the above student to receive medication at school.

I also give district employees permission to contact the student's physician directly to provide information on the student's condition or clarify medication administration instructions. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication and for informing the school district immediately if any information provided on this form changes or if administration of medication should cease.

_____ _____

Signature Relationship Date

Phone number(s):_____