

NATURAL SCIENCE ACADEMY AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Name of Student _____ Birthdate _____

School Year 2010 - 2011 Grade _____ Teacher _____

Medical Condition	Medication	Strength	Dose	Time	Route	Possible Side Effects
1.						
2.						
3.						
4.						

Other considerations/directions: _____

Start Date: _____ Stop Date: _____
(All authorizations expire at the end of the school year.)

ALL medications (over the counter drugs included) require a Physician's signature.

Print or Type Name of Physician/Licensed Prescriber

Physician's/Licensed Prescriber's Signature

Clinic Address

Phone Number

Date

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medications(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
3. I will notify the school of any change in the medication(s), (ex: dosage change, medication is discontinued, etc.).
4. I give permission for the school nurse to communicate with the student's teachers about the student's health condition(s) and the action of the medication(s).
5. I give permission for the school nurse to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).
6. I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.

Date

Parent/Guardian Signature

Relationship to Student

NOTE: Medication is to be supplied in the original/prescription bottle.