

PARENT'S AUTHORIZATION FOR ADMINISTERING  
MEDICINE AT SCHOOL

Date: \_\_\_\_\_

Student's Name: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Is medication given by inhaler?      Yes \_\_\_\_\_      No \_\_\_\_\_

Purpose: \_\_\_\_\_

Time (s) to be Administered: \_\_\_\_\_

\_\_\_\_\_

Dosage: \_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

Termination Date for Administering Medicine: \_\_\_\_\_

This certifies that I, the undersigned parent/guardian, am aware of the terms of the above authorization and hereby request that they be carried out accordingly.

Signed: \_\_\_\_\_

Parent/Guardian

Date: \_\_\_\_\_