



(Return to Teacher with Medication)

AUTHORIZATION FORM to ADMINISTER MEDICATION

Name of student: _____

Medication: _____

Time medication needs to be given: _____ a.m. _____ p.m.

To be given from (date): _____ to _____

Significant information (include side effects, toxic reactions, etc.): _____

Contraindications for administration: _____

If an emergency situation occurs during the school day or if the student becomes ill, school officials are to:

- Contact the parent at: _____
- Contact the physician's office at: _____
- Take child immediately to the emergency room at: _____

This medication will be furnished by the parent or guardian within a properly labeled container by a pharmacist with identifying information, (name of child, medication dispensed, dosage prescribed, and the time to be given).

Physician's Signature

Date

PARENT'S PERMISSION

I hereby give my permission for my child to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release Community School of Davidson and its employees from all liability that may result from my child taking the prescribed medication.

Parent or Guardian Signature

Date