STUDENT MEDICATION AUTHORIZATION FORM

Authorization to Administer

Student Name ______________________________________ Grade__________

I am hereby granting The Way Academy permission to administer the following medication(s) to the student named above.

Section 1 – Over the Counter Medication(s):

No medications, including cough drops, pain/fever reduction medication or anti-itch ointment, will be dispensed without written authorization from a doctor. The following medications may be administered as needed throughout the school year.

Name of Medication	Exact Dosage to be given	Date/Time/to be given

Section 2 – Prescription (Oral) Medication(s):

Name of Medication	Exact Dosage to be given	Time to be given	Begin Date	End Date

It is necessary that this prescription medication be provided during the school day due to the following medical condition(s): ____

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Section 3 – Comments/specific instructions regarding administering these medications:

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All medication must be received in the original container and be delivered and retrieved by the parent/guardian only. A student should not carry medication on his/her person or take medication at school, except in the clinic.

_______________________ _______________________

Parent Signature Prescribing Physician Signature

_______________________ _______________________

Date Prescribing Physician Print Name