# MEDICATION AUTHORIZATION

***2015-16 School Year***

**MEDICATION REQUIREMENT:** **Prescription Medication** shall be in the original container and labeled with the student's name, instructions, including times and amounts for dosages, and the physician's name. All **non-prescription medications** shall be in the original container and labeled by the parent with the student's name and instructions for administration, including times and amounts for dosages.

**Student's Name:** ___________________________________ **Date:**_____________________________

**Name of Medication:** _________________________________________________________________

**Possible Side Effects:** _________________________________________________________________

**Reason for Medication:** ______________________________________________________________

**Date Medication Begins:** _________________________ **Date Ends:** _________________________

**Dosage:** _______________________ **Time/Frequency to be Administered:** _____________________

**Signature/Phone Approval of Parent/Guardian:** __________________________________________

**Date:** ____________________ **Office Staff:** ____________________________________________


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