FORM – 3.5.1 MEDICATION ADMINISTRATION AUTHORIZATION FORM

SECTION 1: STUDENT INFORMATION

Student Name: _____
Grade: _____ Date of Birth *(DD/MM/YYYY):* ____/____/_____
School: _____ Grade: _____
Teacher: _____
Parent/Guardian Name: _____
Primary Phone: _____ Secondary Phone: _____
Emergency Contact Name & Phone #:
_____

SECTION 2: MEDICATION INFORMATION

Medication Name: _____
Dosage: _____
Route of Administration *(e.g., oral, inhaled, injected):* _____
Time(s) to be Administered at School: _____
Start Date *(DD/MM/YYYY):* ____/____/_____ End Date *(DD/MM/YYYY):* ____/____/_____
Reason for Medication: _____
Possible Side Effects: _____

SECTION 3: PHYSICIAN AUTHORIZATION *(REQUIRED FOR PRESCRIPTION MEDICATIONS)***

Physician Name:_____

Phone Number: _____

Address: _____

I authorize school personnel to administer the medication as prescribed above.

Physician Signature: _____

Date *(DD/MM/YYYY):* ____/____/_____

SECTION 4: PARENT/GUARDIAN AUTHORIZATION

I request and authorize school personnel to administer the medication described above to my child. I understand that:

- The medication must be provided in the original container with clear labeling.
- Any changes in dosage or medication require a new form and physician authorization (if applicable).
- It is my responsibility to provide and retrieve medication as needed.
- The school is not responsible for adverse reactions that may occur under proper administration.

Parent/Guardian Signature: _____ Date *(DD/MM/YYYY):* ____/____/_____

SECTION 5: SCHOOL USE ONLY

Received By (School Personnel): _____. Date *(DD/MM/YYYY):* ____/____/_____

Medication Stored Securely: ☐ **Yes** ☐ **No**

Administrator Signature: _____