Authorization to Administer Medication

Medication cannot be dispensed unless this form is completed in full, thank you!

Date: ____________________ Student's full name:____

Name of Medication: ___________________________________ Doctor:____

Prescription Number (if any): ____________________________ Dosage:____

Dates to be given: ______________________________________ Time to be given: ______________________________________

Special Instructions: ____

____

____

Parent Signature:____

Medication Administration Verification

Date	Time	Dosage	Adverse Reaction	Staff	Date	Time	Dosage	Adverse Reaction	Staff