MEDICATION ADMINISTRATION AUTHORIZATION

FOR PARENT-SUPPLIED MEDICATIONS (OTHER THAN TYLENOL/ADVIL)

DATE: _____

SCHOOL YEAR: _____

I hereby give permission for my child, _____, to have the following medication administered by the school nurse, or designated school personnel during the school day.

Name and dose of medication: _____

Time to be given: _____

How soon can the medication be repeated: _____

Date to begin: _____ Stop date: _____

Reason for medication: _____

If medication to be provided "when needed", describe indications:

_____

Signed: _____

PHYSICIAN signature *(not required if medication is in the bottle from the pharmacy with the child's name and the name and dose of the medication)*

Signed: _____

PARENT signature *(required for **all medications**)*

NOTE:

- Please review the full Medication Administration Policy at www.lhps.org/parents/health-services.
- All medications administered at school must be checked in at the clinic with the required authorization.
- Medication must be received in its original container and be labeled with the student's name.
- This authorization is valid only for the current school year and must be renewed.