AUTHORIZATION FOR MEDICATION

I AUTHORIZE THE CLINIC TO GIVE THE FOLLOWING MEDICINE TO

Student Name:_____ **Grade/Teacher:**_____

Name of Medicine	Amount	Method	Time of Day	Date From	Date To

I UNDERSTAND THAT MEDICINE MUST BE IN THE ORIGINAL LABELED CONTAINER. ALL NON-PRESCRIPTION MEDICINE MUST BE LABELED WITH PROPER DOSAGE FOR CHILD'S AGE OR WEIGHT, OR ACCOMPANIED WITH A DOCTOR'S NOTE.

SIGNED_____ **DATE**_____

(Parent / Guardian)

_____

(Parent / Guardian Printed Name)

Name of Medicine	Amount Given	Method	Date	Time of Day	Signature of Staff