School District Dispensing Medicine Form

I hereby authorize medication _____
(Name & Prescription Number)

For my child_____

To be administered at_____
(School)

Reason child is taking medication: _____

_____

Procedure for dispensing medication (i.e. when administered, etc.):

TIME:_____

DOSAGE: _____

DURATION: _____

ROUTE: _____

Doctor: _____

_____

Parent/Guardian Signature_____ Date _____

_____
*Verbal permission received by: Time/Date

*Written authorization to follow within 24 hours.