PARENT'S AUTHORIZATION FOR MEDICATION

2010-2011

Teacher: _____ Grade: _____

Name of Child: _____ Date of Birth: _____

Name of Medication: _____ RX Number: _____

Prescribing Physician: _____ Continue Until: _____

Dosage: _____ When to give: _____

Signature of Parent or Guardian: _____ Date: _____

★ ***Medicine must be in the original container with the child's name clearly written on the container.*** ★

MEDICATION LOG:

Amount	Time	Date	Initials

All medication must be administered by an authorized adult:

- ✓ Early Childhood and Lower School: *Classroom teacher*
- ✓ Middle and Upper School: *Administration*