

**AUTHORIZATION TO ADMINISTER PRESCRIPTION  
MEDICATION IN SCHOOL**

NAME OF CHILD: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

NAME OF MEDICATION: \_\_\_\_\_

DOSAGE: \_\_\_\_\_

FREQUENCY GIVEN & DIRECTIONS: \_\_\_\_\_

\_\_\_\_\_

PURPOSE OF DRUG: \_\_\_\_\_

POSSIBLE SIDE EFFECTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I authorize the School Nurse or her designated substitute in the event she is absent to administer the above medication to my child during regular school hours and at other times when my child is participating in a school related event. I understand that the Community School, school nurse and other school employees shall incur no liability as a result of any injury arising from the administration of this medication; that I will indemnify and hold harmless the Community School, school nurse and other school employees against any claims arising from the administration to my child.

\_\_\_\_\_  
(Signature of M.D.)

\_\_\_\_\_  
(Parent's Signature)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Phone No.)

\_\_\_\_\_  
(Physician's Stamp)

*This permission is effective for the current school year only and must be renewed annually.*

VERIFICATION OF QUANTITY  
OF PRESCRIPTION MEDICATIONS

To: School Nurse, Community High School

From: \_\_\_\_\_  
Parent Name

Student Name: \_\_\_\_\_

THIS FORM MUST ACCOMPANY ALL  
MEDICATIONS/PRESCRIPTIONS

I am providing the school with the following medications and quantities to be administered at the school to be brought to the school by a responsible adult or sent to Community High School by mail, U.P.S. or some other carrier. No students can transport medications to or from school. All proper authorization forms have previously been sent.

<u>Prescriptions/ Medication Names</u>	<u>Quantities Sent</u>	<u>Date Sent</u>	<u>Parent Instructions</u>

Signed: \_\_\_\_\_

\_\_\_\_\_

Parent