



**CONFIDENTIAL**

**PRESCRIPTION MEDICATION  
ADMINISTRATION /DISPERSAL  
AUTHORIZATION**

All prescription medications must be provided in containers with the patient's name, date issued and dosage requirement to act as a physicians directive and therefore will not require a doctor's written authorization. Please note that all medications should be taken home no later than the last class day of each semester to maintain current prescription expirations and dosages.

**TO BE COMPLETED BY PARENT/GUARDIAN**

**Child's Name:** \_\_\_\_\_  Male  Female

**Student ID:** \_\_\_\_\_

**Student's Date of Birth:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

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**Name of Prescription:** \_\_\_\_\_

Dose: \_\_\_\_\_ Time to be given: \_\_\_\_\_ Method to be given: \_\_\_\_\_

Is child authorized to medicate himself/herself?  Yes  No

Dates of service start: Month: \_\_\_\_\_ Year \_\_\_\_\_ End Date: Month: \_\_\_\_\_ Year \_\_\_\_\_

Special instructions: \_\_\_\_\_

\_\_\_\_\_

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**Name of Prescription:** \_\_\_\_\_

Dose: \_\_\_\_\_ Time to be given: \_\_\_\_\_ Method to be given: \_\_\_\_\_

Is child authorized to medicate himself/herself?  Yes  No

Dates of service start: Month: \_\_\_\_\_ Year \_\_\_\_\_ End Date: Month: \_\_\_\_\_ Year \_\_\_\_\_

Special instructions: \_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_ **Date**                      \_\_\_\_\_ **Parent/Guardian Signature**                      \_\_\_\_\_ **Home Telephone**                      \_\_\_\_\_ **Emergency No.**