**Summer 2020**
**MEDICINE AUTHORIZATION FORM**
**(This form must be replaced EVERY school year and for summer camps.)**

Dear Parents/Guardians:

**We can only administer medications that are prescribed by a physician**. Medication must be brought to school in the **original, labeled prescription container and/or box** by a parent or guardian. This form and the prescribed medication cannot be accepted without the prescribing physician's signature below.

Student Name:_____

Teacher/Grade:_____

Name of Medication: _____

Time and amount student will receive medication at home:_____

Time and amount student will receive medication at school:_____

Refrigeration required? _____ Yes _____ No

Date of Prescriptions:_____ Amount left at school:_____

Medication directions (as on label):_____

_____

Duration and expiration of prescription:_____

_____ _____
Parent/Guardian Signature Date

_____ _____
Printed Name Daytime Phone Number

Name of physician who prescribed medication: _____

_____ _____
Physician Signature Date

**For Office Use Only:**

Date Prescription Received for
Current School Year or Summer Camp:_____

Prescription Distributed to Teacher(s):
_____
_____
_____
Date and Signature(s)

Revised 7/22/2016