

The Madeira School

Medication Administration Authorization Form

This form must accompany all routine and optional prescription and over-the-counter medication, including vitamin, supplement, herbal, and homeopathic products other than those listed on the Over the Counter Medication Permission form.

****Parent/Guardian Signature REQUIRED for all medications.****

****Physician Signature REQUIRED for all prescription medications.****

Student Name: _____ **Date of Birth:** _____

Parent Name: _____

Medication Name: _____

Prescribed Dosage: _____ Medication Strength: _____

Frequency/Time of Administration: Morning Noon Evening Bedtime Other: _____

Mandatory Optional Comments: _____

Start Date: _____ End date (If Applicable): _____

Medication Name: _____

Prescribed Dosage: _____ Medication Strength: _____

Frequency/Time of Administration: Morning Noon Evening Bedtime Other: _____

Mandatory Optional Comments: _____

Start Date: _____ End date (If Applicable): _____

Discontinued Medication Name: _____

Prescribed Dosage: _____ Medication Strength: _____

Frequency/Time of Administration: Morning Noon Evening Bedtime

End date: _____

Special Instructions:

I give permission to the school nurse or other authorized personnel to administer the above medication(s) to my child. *Should a change in any of the above information occur, I understand that a revised, written physician's statement and parent/guardian authorization must be submitted.*

Parent Signature: _____ Date: _____

Physician Name: _____ Phone/Email: _____

Physician Signature: _____ Date: _____