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: __________________