

Authorization for Distribution of Prescribed Medication

Child's Full Name: _____

Name of Medication: _____

Prescription Number: _____

Time(s) Medication is to be Given: _____

Dosage of Medication to be Given: _____

Dates to be Given: _____

Signature of Parent/Guardian

Date

- **ANY PRESCRIBED MEDICATION MUST COME TO SCHOOL IN ITS' ORIGINAL PRESCRIPTION CONTAINER.**

FOR SCHOOL USE ONLY

Date	Time Given	Dosage	Adverse Reaction	Administered By

If noticeable adverse reaction to medication was observed, what action was taken? Describe
