

**COLCHESTER SCHOOL DISTRICT**

**AUTHORIZATION TO ADMINISTER MEDICATION AT SCHOOL**

No Medication will be given at school until the school receives this completed form with the prescribed medication in a properly labeled pharmacy container.

We have been asked to administer medication to the student listed below at school. If this meets your approval, please complete the form below and return it to our school at the address / fax below. Authorizations are good for the entire school year. Shorter periods may be specified.

Student Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Condition requiring medication: \_\_\_\_\_

Medication to be administered: \_\_\_\_\_

Dosage and mode of administration: \_\_\_\_\_

Time of administration: \_\_\_\_\_

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

Duration if less than the current school year: \_\_\_\_\_

I hereby authorize the administration of the above medication for the student listed above in accordance with the school district's medication administration policy while the student is under the supervision of school personnel.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

.....  
To be completed by parent/guardian:

I hereby give permission for the above physician to communicate with the school listed above about my child and their medication needs. I also give permission for my child to take the medication as prescribed above at school.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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To be complete by school officials:

Nurse Signature: \_\_\_\_\_ Date received: \_\_\_\_\_

School Name: \_\_\_\_\_ Phone: \_\_\_\_\_

School Address: \_\_\_\_\_ Fax: \_\_\_\_\_

