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.

TO BE COMPLETED BY PHYSICIAN:Authorizations are good for the 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: _____

Student should/is able to Self Carry YES_____ NO_____

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: _____

To be complete by school officials:

Nurse Signature: _____ Date received: _____

School Name: _____ Phone: _____

School Address: _____ Fax: _____