Sample

Medication Authorization and Administration Form
Anytown Adventist School

Student's Name _____ Date: _____

Student's Address _____ Date of Birth: _____
Street Address Month/Day/Year

_____
City, State, Zip or Postal Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Parent's Name(s): _____

Doctor's Name: _____ Doctor's Phone: _____

I hereby request and authorize school personnel to administer the prescribed medication as directed by our doctor.

_____
Parent or Guardian Signature

Cut here.....Cut here

Doctor's Orders

You are hereby directed to give _____
Name of Child

their medication, _____
Name of Medication

in the amount of _____ tablets/capsules at _____ a.m./p.m. daily or as follows, _____

_____ .

Duration: _____

Possible Side Effects: _____

_____ _____ _____
Doctor's Signature Date Phone