



# Medication Authorization Form

Beginning date: \_\_\_\_\_

Ending date: \_\_\_\_\_

Student Name: \_\_\_\_\_

Grade: \_\_\_\_\_ School: \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Dosage Amount: \_\_\_\_\_

Times Administered: \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Dosage Amount: \_\_\_\_\_

Times Administered: \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Dosage Amount: \_\_\_\_\_

Times Administered: \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Dosage Amount: \_\_\_\_\_

Times Administered: \_\_\_\_\_

Refrigeration required: Yes \_\_\_\_\_ No \_\_\_\_\_ Medication: \_\_\_\_\_

Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I give my permission for Madison Consolidated Schools staff to administer the above medication to \_\_\_\_\_ (child's name) as indicated above.

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

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**Students in Grades 9-12 only**, I authorize the school personnel to allow my child above to transport home any unused portion of the above medications.

Student in Grades K-8, I authorize \_\_\_\_\_ (must be over the age of 18) to pick up any unused portion of the above medications.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE RETURN TO SCHOOL