Medication Authorization Form

Student Name:_____
Grade:_____School: _____
Begin Date:_____ End Date:_____

Name Of Medication:_____ Dosage Amount:_____
Time Administered:_____

Date	Quantity Provided by parent or guardian	Parent (initial)	Nurse (initial)	Date	Quantity Provided by parent or guardian	Parent (initial)	Nurse (initial)

Refrigeration Required: Yes_____ No_____ With food: Yes_____ No_____
(parent to provide if necessary)

Name Of Medication:_____ Dosage Amount:_____
Time Administered:_____

Date	Quantity Provided by parent or guardian	Parent (initial)	Nurse (initial)	Date	Quantity Provided by parent or guardian	Parent (initial)	Nurse (initial)

Refrigeration Required: Yes_____ No_____ With food: Yes_____ No_____
(parent to provide if necessary)

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

Parent Signature: _____ Date:_____