Norton City Schools
Authorization for Medication Administration

PARENT/GUARDIAN SECTION

Student__________________________ DOB__________ Age_______ Grade_______

School______________________ Homeroom Teacher_____________________________

Parent/Guardian Signature_______________________________ Date________________

Parent/Guardian Printed Name_____________________________

Signature gives permission for principal's designee to administer prescribed medicine and gives principal's designee permission to contact physician/dentist if necessary. For Over-the-Counter medicine, parent's signature gives principal's designee permission to administer medicine.

PHYSICIAN/ DENTIST SECTION
(Must be completed by Physician/ Dentist)

PRESCRIPTION MEDICATION:

Name of Medication: ____

Reason medication is needed, unless confidential: _______________________________

Dosage: ________________________ Length of Time: __________________________

Time of day to be given: ____

If potentially serious side effects exist, please outline any necessary emergency response on a separate sheet.

Physician/ Dentist Signature______________________________ Date: ______________

Physician/ Dentist PRINTED Name____

Physician/ Dentist Phone_________________________ Fax________________________

Physician/ Dentist Address____

OVER-THE-COUNTER MEDICATIONS:

Name of Medication: ____

Dosage/ Length of Time: ____

Time of Day to be Given: ____

Side Effects: ____

Received by: ____ Date: ______________

Distribution: Original with medication, copy to Student Health Record, copy to Physician.