Parshall Elementary School

Medication Administration Authorization

Please complete this form if you want PES staff to administer prescription and/or non-prescription medications to your child. One form must accompany each medications to be administered. All medication must be in their original containers.

Child's Name_____DOB_____Grade_____

Parent/Guardian_____Teacher_____

Home Phone_____Work Phone_____Cell Phone_____

Physician Name and Phone if prescription_____

Authorization for Medication Administration

*Medication*_____*Dosage*_____*Time Given*_____

Route (Circle One)

By Mouth Inhale/Nasal Apply to Skin Apply to Eyes Drop in Ears Other_____

*Instruction for use*_____*Side Effects*_____

*Other Information Staff Should Know*_____

Authorization:

I give permission to Parshall Elementary School staff to administer this medication. I will notify the school immediately if anything changes with the above medication.

I have read and understand the above information. I give Parshall Elementary staff permission to administer the above medication to my child.

Parents Signature_____Date_____