ORANGE COUNTY

AUTHORIZATION FOR MEDICATION

My permission is hereby granted to ___________________________
(NAME OF SCHOOL)

to assist ______________________________________in taking the
(FULL NAME OF STUDENT)

prescribed or over- the counter medication described below.

Name of medication____________________________________

Name of authorizing physician____________________________

Directions for administering_______________________________

Amount to be given_____________________________________

Time(s) to be given_____________________________________

Date to begin__________________To stop__________________

Explain the necessity of the medication to be provided:_________
____
____

It is hereby understood by the undersigned, that school personnel are not held liable for the administration of the above medication or its possible side effects.

Medication is to be sent in its original container. Duplicate containers can usually be obtained from the pharmacist for home storage if needed. For safety and security reasons, it is recommended that medication be brought to school by the parent/guardian, not sent to school by the child.

_____________________________ _____________________
SIGNATURE OF PARENT/GUARDIAN DATE

_____________________________ _____________________
PHYSICIAN'S SIGNATURE DATE