



Date: _____
Teacher: _____
Grade: _____

MEDICATION AUTHORIZATION FORM

In order to dispense medication to your child, a current form must be completed and placed on file at the school.

Student Information

Student Name: _____
(Last) (First) (Middle)
Any known allergies/reactions: _____

Prescribing Physician Authorization (prescription medication)

(Please complete all spaces)

Prescribing physician: _____
Name of medication: _____ Strength: _____
Reason for taking: _____
Dates to be given: _____ Time(s) to be given: _____
Dosage: _____
If asthma inhaler or emergency medication, do you recommend this medication be kept "on person" by student? _____
Possible side effects or adverse reactions: _____

Suggested treatment in event of adverse reactions: _____

(Signature of Prescribing Physician)

(Date)

(Telephone)

Medication Instructions (nonprescription medication)

(Please complete all spaces)

Name of medication: _____
Reason for taking: _____
Date(s) to be given: _____ Time(s) to be given: _____
Dosage: _____

(Signature of Parent)

(Date)

(Telephone)

Parent Authorization and Release

I authorize such school personnel as may be designated by the Headmaster to assist my child in taking the above medication. I understand that additional signed authorizations will be necessary if the dosage of medication is changed.

I acknowledge that the medication must be registered with the school counselor or her designee. It must be in the original container and properly labeled with the name of student, name of physician, name of medication, date of prescription, strength, dosage, and the date of the drug's expiration when appropriate.

I hereby release Houston Academy, its officers and employees from any and all liability, of any nature and character, which may be alleged to arise out of or relating to the administration of the medication described above, provided such administration is in substantial conformity with the above instructions.

I also give the physician listed permission to release medical information to the school counselor if there is any question about this medication and its administration.

(Signature of Parent or Guardian)

(Date)

Please contact me at this number if there is any problem with this medication _____