AUTHORIZATION TO ADMINISTER MEDICATION AT SCHOOL

Please complete the following if the medication named below is to be given during school hours in order to keep this child in optimal health and help maintain school performance. ALL MEDICATIONS MUST BE IN THEIR ORIGINAL CONTAINER AND TURNED IN AT THE FRONT OFFICE.

NAME OF STUDENT: ____________________________________ GRADE: _______ TEACHER:______________________

Diagnosis or Reason for Medication: ____

Name of Medication: ____

Dosage and Time: ____

Common Side Effects: ____

Medication Usage: ☐ As Needed

(Check all that apply) ☐ From :____________________(mm/dd/yy) To: ____________________(mm/dd/yy)

Physician Section Required For Prescription Medications.

PHYSICIANS: Please sign and return this authorization form to the parent or the school as soon as possible.

____

Physician's Name (print or type) Physician's Signature

____

Telephone Number Fax Number

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PARENTS: *I hereby give permission for Aristoi Classical Academy to administer the medication listed above to my child, as requested by me or the above physician.*

____

Parent's Signature Date

____

Telephone Number Fax Number