



**HAMILTON COUNTY DEPARTMENT OF EDUCATION
School Health Program**

**PARENT/GUARDIAN
AUTHORIZATION TO ADMINISTER MEDICATION AT SCHOOL**

I hereby authorize _____ staff to administer the medication
(School)

described below to my child, _____. I understand that the
(Student's Name, DOB)
teacher or other school personnel will administer only the medication described below. If
the prescription is changed, a new form for parent consent and a new physician's order
must be completed before the school staff can administer the new medication.

Signature Date

**HEALTH CARE PROVIDER
AUTHORIZATION TO ADMINISTER MEDICATION AT SCHOOL**

The following medication(s) has been prescribed for the treatment of _____.

Please administer:

NAME OF MEDICATION	INDICATION	DOSAGE	ROUTE	TIME
1.				
2.				
3.				

In my opinion, this medication is necessary during the school day.

The common side effects can include: _____

Allergies: _____

Licensed Healthcare Provider

Date