AUTHORIZATION FOR STUDENT MEDICATION

To the Principal of _____ School Date_____

I, the parent/guardian of _____, whose birth date is_____, request the following medication be given to my child during school hours. I release school personnel from any liability involved with administering this medication according to the doctor's instructions below. I understand that this form is valid only with a licensed medical provider's signature. I authorize the school nurse and the medical provider to communicate as needed to ensure the safe administration of the medication. I UNDERSTAND THAT THIS AUTHORIZATION IS IN EFFECT FOR ONE YEAR AND A NEW FORM MUST BE SIGNED BY A MEDICAL PROVIDER EACH SCHOOL YEAR.

_____ _____ _____

Parent Signature Parent's Printed Name Date

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