MEDICATION AUTHORIZATION/INSTRUCTIONS

This medication is for: ____ Grade ___

Medication(s): ____________________ Dosage prescribed: ___________ Expiration date: ________

____________________ Dosage prescribed: ___________ Expiration date: ________

____________________ Dosage prescribed: ___________ Expiration date: ________

Physician Name: ____ Phone Number: ________

Physician Signature: ____ Date: _________

Instructions for the school office are: ______________________________

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Name (parent/guardian) PLEASE PRINT: ____

Signature (parent/guardian) ___________________________________ Date: _________

Approved (Principal) ____ Date: _________