AUTHORIZATION FOR DISPENSING OF MEDICATION

I, the undersigned parent and/or guardian of:

_____ _____ Date of Birth: _____/____/_____
(Student's Name) (Grade/Room #) Mo Day Yr

Authorize and request that my minor child be provided the medication listed below by a trained adult staff member or volunteer according to the instructions provided and, when necessary authorize the School to contact the licensed prescriber regarding administration of the medication.

NAME OF MEDICATION: _____

DOSE: _____

TIME TO BE GIVEN: _____

DURATION: _____

ADDITIONAL ADMINSTRATION INFORMATION: _____

_____

ATTACH DOCTOR'S NOTE AND PRESCRIPTION REGARDING EMERGENCY CARE PLAN AND ADMINISTRATION OF MEDICATION.

☐ **Check here if this release is for a metered dose asthma inhaler, insulin pump or epinephrine auto-injector, which the student will possess and use at his/her own discretion in school or at school activities. The physician and parents/guardian signature below apply to the inhaler, insulin pump or epinephrine auto-injector possession and use by students as permitted in the Revised School Code.**

_____ _____ _____
(Doctor's Signature) (Please Print Name) (Date)

( ) _____
(Phone Number)

PARENT/GUARDIAN _____
(Signature)

_____
(Print Name)

DATE _____