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