

THIS ENTIRE FORM MUST BE FILLED OUT PRIOR TO ANY ADMINISTRATION OF ANY MEDICATION.

Parent/ Guardian Authorization to Administer Medication at School

I hereby authorize AMERICAN LEADERSHIP ACADEMY staff to administer the medication described below to my child _____. I understand the teacher to other school personnel will administer only the medication described below. If the prescription is changed, a new form for consent and a new physician's order must be completed before the school staff can administer the new medication.

MEDICATION MUST BE TRANSPORTED TO AND FROM SCHOOL BY AN ADULT. WE CANNOT MAKE EXCEPTIONS.

Date _____ Parent/ Guardian Signature _____

HEALTH CARE PROVIDER AUTHORIZATION TO ADMINISTER MEDICATION AT SCHOOL.

(THIS NEEDS TO BE FILLED OUT BY THE CHILDS MEDICAL DOCTOR)

The following medication(s) is/are prescribed for the treatment of:

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Please administer:

Name of Medication	Dosage	Route	Time	Dr Prescribed/ Over the counter
1				
2				
3				

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

The common side effects can include:

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Date: _____ Signature: _____

PARENT/GUARDIAN INFORMATION

Print Name _____

Home Phone _____ Cell/Work _____

CHILDS INFORMATION

Print Name _____

Grade _____ Teacher _____

Age _____ Birth date _____