

**AUTHORIZATION FOR ADMINISTRATION OF
NON-PRESCRIPTION MEDICATIONS**

STUDENT NAME

DATE

MEDICATION _____ **TIME TO BE**
GIVEN _____

DOSAGE
AMOUNT _____

—

PARENT
SIGNATURE _____

—

SPECIAL
INSTRUCTIONS: _____

—

**Please note that medications will be returned home at the end of the day
UNLESS you indicate otherwise. Medications must be sent in their
ORIGINAL CONTAINERS. Thank you.**