Medication Authorization Form

Parent / Guardian Form

Draft for school review and approval - July 2026

Complete this form before medication is brought to school. Medication should be provided in its original labelled container.

Student Name _____

Grade _____

Date of Birth _____

Parent/Guardian Name _____

Primary Phone _____

Emergency Phone _____

Medication Details

Medication Name _____

Dosage _____

Time(s) to Administer _____

Method / Route _____

Start Date _____

End Date _____

Reason for Medication _____

Known Side Effects or Special Instructions

_____

Prescriber / Pharmacy

Prescriber Name _____

Prescriber Phone _____

Pharmacy Name and Phone _____

Emergency Instructions

Describe what staff should do if the medication is missed, refused, vomited, or if an adverse reaction occurs.

_____

_____

Acknowledgement

I authorize designated school staff to store and administer the medication according to the instructions above. I understand that the school may contact me, the prescriber, pharmacist, or emergency services when necessary.

☐ I confirm that the information provided is accurate. ☐ I will notify the school if this information changes.

Parent/Guardian Signature _____

Date _____