Medication Authorization Form

2021-2022 Academic School Year

Name:___________________________________ Grade:___________________

Name of Medication:_____________________________ Dosage:_____________

Time of Day:__________ From:______________To:______________________

Possible Side Effects:____

Physician's Name:__________________________ Phone:___________________

Address:____

Parent/Guardian Permission:

I grant permission for ______________________________________ to receive
(student name)
______________________________ at West Sound Academy for the prescribed
(name of medication)
period of time. I understand the school will contact me if and when additional medication is required. It is my responsibility to see that the school receives the medication in its original container.

____ ____________________
Parent/Guardian Signature Date

Prescription medications must be brought to the office in the original container along with this signed authorization form.

Revised 7/15/2021