

Medication Authorization Form

2022-2023 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.