



# STUDENT MEDICATION

## Authorization to Administer

Please be sure to complete section 1 prior to submitting to your physician.

Student Name \_\_\_\_\_ Grade \_\_\_\_\_

I am hereby granting The Master's Academy permission to administer the following medication(s) to the aforementioned student:

### SECTION 1

Over the Counter Medication(s): *May be administered as needed throughout the school year*

Name of Medication	Exact Dosage/Amount to be given	Date/ Time(s) to be given

### SECTION 2

Oral Prescription Medication(s): *\*See Alternate Forms for Inhaled or Injectable Medications*

Name of Medication	Exact Dosage/Amount to be Given	Begin date	Stop Date

It is necessary that this prescription medication be provided during the school day due to the following medical condition(s): \_\_\_\_\_

### SECTION 3

Additional comments or specific instructions: \_\_\_\_\_

*This information will remain confidential and only shared with school personnel, as needed, for the student's health and educational needs. This authorization includes permission for communication between the school nurse and student's health provider, regarding the medications, if necessary.*

\_\_\_\_\_  
**Prescribing Physician Signature (REQUIRED)**

\_\_\_\_\_  
**Prescribing Physician Printed Name**

\_\_\_\_\_  
**Parent Signature**

\_\_\_\_\_  
**Date**

*All medications must be received in original containers and be delivered and retrieved by parent/ guardian only. A student must never carry medication on his/her person or take medication at school, except in the Clinic.*

**Grades K4 - 5th Fax Number: 407-706-1373**

**Grades 6 - 12 Fax Number: 407-971-1373**

**Nurse E-mail: [annbirkmire@mastersacademy.org](mailto:annbirkmire@mastersacademy.org)**