



STUDENT MEDICATION

Authorization to Administer

If your child needs to have medication given by school personnel during the school day, state law requires that your and your physician provide written authorization for administration of both prescription and over-the-counter medication.

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 I

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
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_____	_____	_____
_____	_____	_____
_____	_____	_____

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
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_____	_____	_____	_____
_____	_____	_____	_____

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

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