THE CONNECTION SCHOOL

Authorization for Dispensing Medication

I hereby request the school faculty/staff to administer the medication names below to my child. I understand that all medications must be in the original container, labeled with the child's name and with directions to administer the medication. Prescribed medication must also include the date and name of physician.

By signing below I release the school and its faculty/staff from all liability.

Parent's Authorization:

Name of Child: _____ Grade: _____

Name of Medication: _____

Please Check: ___ PRESCRIPTION ___ NONPRESCRIPTION

Prescribing Physician_____

Dosage: _____ When to Give: _____

Continue Medication Until (Date): _____

Special Instructions:

I UNDERSTANDTHAT I AM TO IMMEDIATELY NOTIFY SCHOOL FACULTY/STAFF IF THERE SHALL BE ANY CHANGES WITH THE PRESCRIBED DOSAGE, TIME TO BE ADMINISTERED, SIDE AFFECTS THAT MAY CAUSE HEALTH PROBLEMS,OR IF THE PRESCRIBING PHYSICIAN RELEASES MY CHILDFROM THE MEDICATION.

Parent/Guardian Name: _____ Signature: _____ Date: _____