



# the king's school

Preparing Tomorrow's Leaders Today

## Authorization for Administration of Medication at The King's School

A. To be completed by the parent or guardian:

I request that my child \_\_\_\_\_, grade \_\_\_\_\_, receive the medication as prescribed below by our licensed health care prescriber. The medications are to be provided to the school by me in the original container, with the child's name and date clearly labeled. I understand that the school nurse will administer the medication or an adult will supervise my child taking his/her own medication as ordered.

Signature (Parent or Guardian): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Date: \_\_\_\_\_

B. To be completed by the licensed health care prescriber:

I request that my patient, as listed below, receive the following:

Name of student: \_\_\_\_\_ DOB: \_\_\_\_\_

Diagnosis (if applicable): \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Indication for Medication: \_\_\_\_\_

Check the one that applies:  DAILY MEDICATION  AS NEEDED MEDICATION

Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route of Administration: \_\_\_\_\_

Time to be taken during school hours: \_\_\_\_\_

Duration of Treatment: \_\_\_\_\_

Possible side effects and adverse reactions (if any): \_\_\_\_\_

Other recommendations : \_\_\_\_\_

Licensed Prescriber and Title (please print): \_\_\_\_\_

Prescriber's  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_