Medication Authorization Form

2019-2020 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.

Revised 6/28/2019