Meadow Glade Adventist Elementary School

Parental Authorization for Over the Counter Medication Administration

Student's Name_________________________________Date______________

Birthdate____________________________________Grade_____________

Name of Medication____

Dosage__________________________ Route of Administration____________

Time of Day to be Given____

Other Instructions____

____

I certify that I am the parent / legal guardian, of the above identified student and authorize the school to administer the above identified medication as indicated above.

Parent Signature _________________________________ Date __________