

Meadow Glade Adventist Elementary School
2023-2024

Authorization for Administration of Prescription Medication at School

Student Name:		Birth Date:
Allergies:	Grade:	Teacher:

MGAES Phone 360-687-5121 / mgaes.org

Student's Name: _____ Birthdate: _____ Grade: _____

This portion of the form is to be completed by the student's physician.

Name of Medication: _____

Dosage: _____ Route of Administration: _____

Time of Day to be given: _____

Other Instructions: _____

I request and authorize that the above-named student be administered the above identified medication in accordance with the instructions indicated above. Medically untrained school personnel may administer medication. This form expires at the end of the school year listed above.

Physician Signature: _____ Date: _____

Physician Name (print): _____

This portion of the form is to be completed by the parent / guardian.

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: _____

Date/Time: _____ Dose: _____ Signature: _____

Date/Time: _____ Dose: _____ Signature: _____

Date/Time: _____ Dose: _____ Signature: _____

Date/Time: _____ Dose: _____ Signature: _____

Date/Time: _____ Dose: _____ Signature: _____

Date/Time: _____ Dose: _____ Signature: _____

Date/Time: _____ Dose: _____ Signature: _____

Date/Time: _____ Dose: _____ Signature: _____

Date/Time: _____ Dose: _____ Signature: _____

Date/Time: _____ Dose: _____ Signature: _____

Student's Name: _____ **Medication:** _____ **Dose:** _____

Date/Time: _____ Dose: _____ Signature: _____

Date/Time: _____ Dose: _____ Signature: _____

Date/Time: _____ Dose: _____ Signature: _____

Date/Time: _____ Dose: _____ Signature: _____

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