2026-2027

Meadow Glade Adventist Elementary School

Authorization for Administration of Prescription Medication at School

Student Name:		Birth Date:
Allergies:	Grade:	Teacher

MGAES Phone 360-687-5121 / lbott@mgaes.org

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.

➢ If medication will be given more than 15 days, please list additional instructions:

____

____

Physician Signature: ____ Date: _____________

Physician Name (print): ____Phone:___________________________

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: __________

April 2026

Student’s Name: ________________________Medication: _________________Dose: ___________

Date/Time: ____________________________ Dose: ___________________________ Signature: _________________________________

Date/Time: ____________________________ Dose: ___________________________ Signature: _________________________________

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