The Meridian School

Authorization to Administer Prescription Medication

Student Name_____

Prescription Medication

Medication must be provided to The Meridian School in the original container with the label intact. Parents are asked to bring prescriptions directly to the main office. ***Each prescription medication requires an Authorization to Administer Prescription Medication form with a doctor's signature.***

Name of medication_____ Storage instructions_____

Dosage_____ Method of administration_____

Time(s) of day to be administered_____ Begin date_____ End date_____

Reason for medication to be given during school hours_____

Possible side effects/emergency procedure in case of serious side effects:

_____

_____

I request and authorize that the above-named Meridian School student be administered the above-identified medication in accordance with the instructions indicated, as there exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Such medication may be administered by medically untrained school personnel.

Physician Signature _____ Date_____

Physician Name _____ Phone_____

Parent Authorization

I certify that I am the parent/guardian of the above-identified student and request and authorize the school to administer the above-identified medication to the above-identified Meridian student in accordance with the prescription or doctor's instructions.

Parent/Guardian Signature _____ Date_____

Parent/Guardian Name _____