

North Kossuth Community School District

Authorization to Administer Medication

Student _____ Age _____ Grade/Room _____

Prescribed by _____ Phone _____

Name of Medication _____

Name of Pharmacy _____

Health Condition _____

Please give the above medication:

Amount _____

Time _____

Starting Date _____ Ending Date _____

Amount Sent _____

I request that the prescribed drugs or medication be administered according to these written directions. I request that his medication be given by a qualified staff person. The student has experienced no previous side effects from the medication. I further agree that the school personal may contact the prescriber as needed and that medication information may be shared with school personal that need to know.

If any medication is left after the last day of school it will be discarded within 24 hours.

Parent/Guardian Signature _____

Date _____ Home phone # _____

Work/Cell phone # _____

Medication will not be given if it has expired or it has an improper label. Please check the container before sending it to the school.