Ft. Madison Community School District
Ft. Madison, Iowa

AUTHORIZATION TO ADMINISTER MEDICATION TO STUDENTS

Due to the necessity for ____
(Name of child)
to receive medication at a time he/she is in attendance at school it is requested the school principal or school nurse administer such medication according to the prescribed time, or delegate someone to do so.

I hereby request and authorize the principles or nurse or person delegated by principle to administer the following medicine:

______________________________________ At ______________________
(Identification of medicine and amount) (time designated)

Do you anticipate any reaction to this medication? ____________________________
____

If answer yes, please comment below: _____________________________________

This medication should be administered for approximately: ____________________

Area physicians and pharmacists have been made aware of these procedures and physicians should have copies of this authorization form. Many physicians will not charge to complete it. The form can be mailed to the school.

____
Signature of Parent/Guardian

____
Signature of Doctor

____
Date