



Medication Authorization Form

HILLSIDE ACADEMY
Medication Authorization Form

Student Information

- Student Name: _____
- Date of Birth: _____
- Grade: _____

Medication Information

- Medication Name: _____
- Condition/Reason: _____
- Dosage: _____
- Time(s) to be given at school: _____
- Method (circle): Oral / Inhaled / Injection / Topical / Other: _____
- Start Date: _____ End Date: _____

Special Instructions

Provider Authorization (REQUIRED for prescription medication)

I authorize this medication to be administered at school as indicated above.

- Provider Name: _____
 - Signature: _____
 - Phone: _____
 - Date: _____
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Parent/Guardian Authorization

I request that the school administer the above medication. I understand that:

- Medication must be in the original labeled container
 - I am responsible for updating the school with any changes
 - I release the school and staff from liability when acting in good faith
 - Parent/Guardian Name: _____
 - Signature: _____
 - Phone: _____
 - Date: _____
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School Use Only

- Medication received by: _____
- Date received: _____
- Stored location: _____