# Medication Authorization and Administration Form
## Blackberry Seventh-day Adventist School

Student's Name _____ Date: _____
Student's Address _____ Date of Birth: _____
City, State, Zip _____

Parent's Name(s): _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Doctor's Name: _____ Doctor's Phone: _____

I hereby request and authorize school personnel to administer the prescribed medication as directed by our doctor.

_____
Parent or Guardian Signature

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### Doctor's Orders

You are hereby directed to give _____
Name of Child
their medication, _____
Name of Medication
in the amount of _____ at _____.
Times
Begin Date: _____ End Date: _____ (not to exceed current school year)

Possible side effects: _____

Doctor's signature: _____ Date: _____