North Cross School

Medical Authorization

I would like to request that the staff at North Cross School administer the following medication _____ during school hours to _____ as a part of his/her medical treatment.

Prescription Medication: _____

Reason for taking: _____

Common side effects: _____

Physician's Signature: _____

Date: _____

I, _____, the parent or guardian of _____, request that the staff at North Cross School administer the medication prescribed above to my child during school hours. I understand that the person who will administer the medication may not be experienced in the evaluation of medication side effects. I also agree to furnish all prescription medications in the original labeled container supplied by the pharmacy. I will send any over the counter medications appropriately labeled with instructions.

Parent or Guardian Signature: _____

Date: _____