Genoa City Joint 2
Prescription Medication Administration Permission

To be completed by parent or guardian:

Child's name_____ Age_____

Parent/Guardian name_____ Daytime phone _____

I hereby by authorize the principal of Brookwood School or his/her designee to dispense or administer this medication as directed by the below named physician. Directions for medication administration and my child's name are on the prescription bottle.

Physician's Name _____ Phone_____

Address_____

Parent/Guardian signature_____ Date_____
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To be completed and signed by physician:

Name of medication_____

Purpose of medication_____

Dosage_____ Time medication to be given at school_____

Possible side effects_____

I hereby authorize the principal or his/her designee to administer the medication as directed and I will accept direct communication from the person dispensing or administering the medication.

Physician's signature_____ Date_____
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_____(Child's name) has my permission to carry his/her own inhaler and administer it to him/herself. I have assumed responsibility to teach him/her proper use of the inhaler and safety precautions involving the inhaler.

Parent/Guardian signature_____ Physician signature_____