Art School Student Medication Authorization Form

Student Information

Student Name

Date of Birth

Grade/Class

Parent/Guardian Name

Contact Phone

Medication Information

Medication Name

Dosage

Route (e.g. oral, topical)

Frequency/Time(s) to Administer

Begin Date

End Date

Reason for Medication

Special Instructions / Possible Side Effects

Authorization

Parent/Guardian Authorization:
I authorize the administration of the above medication as prescribed.

Parent/Guardian Signature

Date

Physician Authorization (if required):
I certify that this medication is necessary during school hours.

Physician Name

Physician Signature

Date