Medication Administration Authorization Form

Student / Patient Information

Name

Date of Birth

Grade/Class

Parent/Guardian Name

Phone Number

School/Facility Name

Medication Information

Medication Name

Dosage

Route

Time(s) to Administer

Start Date

End Date

Reason for Medication

Special Instructions (e.g., storage, side effects, allergies)

Prescriber Information

Prescriber Name

Phone

Fax

Parent/Guardian Signature

Date

Prescriber Signature

Date