Square One Kids Academy

The Right Foundation to Reach New Heights

MEDICATION AUTHORIZATION FORM

This information should be completed by the PARENT/GUARDIAN.

I hereby give permission for my child, _____ to be given the medication listed below as per the orders stated by his/her doctor. I have given my child at least one dose of this medication and have not seen any adverse reactions to it. I am aware I must send the medication into school in its original container/dispenser that is clearly labeled with my child's name. I must provide the appropriate measuring dispenser(s) for it. I give the Director permission to contact my child's doctor or the pharmacist, should she have any questions or concerns regarding the medication and/or dose.

Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____

Date: _____

*Please give us any additional information here, such as details of how your child does taking this medication and if there are any special instructions to giving it to him/her.

_____

_____

_____

This information must be completed by the child's DOCTOR.

Child's Last Name: _____ Child's First Name: _____

Child's Date of Birth: _____

Name of Medication: _____

Dosage of Medication: _____

Reason for Medication: _____

Time(s) Medication Should Be Given: _____

Start Date: _____ End Date: _____

*Possible Side Effects: _____

Doctor's Name: _____

Doctor's Phone #: _____

Doctor's Signature: _____

Date: _____

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