Osage R-3 School (20__-20__School Year)
Medication Authorization Form

Parent or Guardian,

I request the nurse or designated school staff member to give:

Name of student: _____ Grade _____

Name of Medication: _____

Time: _____ Dose: _____

Date from: _____ to: _____

For Treatment of: _____

Prescribing Physician: _____Phone _____

Parent/Guardian Signature _____ Date _____

Parent Phone Numbers _____/_____

PLEASE RETURN THIS FORM WITH THE PROPERLY LABELED MEDICATION IN THE ORIGINAL, CURRENT BOTTLE. THE PHARMACIST WILL PROVIDE AN EXTRA BOTTLE FOR SCHOOL.