Xavier Charter School
1218 North College Road
Twin Falls, Idaho 83301
Phone: 208.734.3947 Fax: 208.733-1348
Web: www.xaviercharter.org

AUTHORIZATION FOR MEDICATION ADMINISTRATION

Student Name: _____ Birthdate: _____

Grade: _____ Teacher: _____

1. Physician's name and phone: _____
2. Name/type of medication: _____
3. Dosage/amount to be given: _____
4. Frequency/times to be administered: _____
5. Possible reaction to medication (side effects, symptoms)
   _____
   _____
6. Stop Date/when to stop giving the medication: _____

Prescription Medication **(a physician signature is required for prescription medication)**

I certify that I am the parent/guardian of the above named student. I request and authorize school personnel to dispense the above named prescription medication to my child in accordance with the prescription/doctors order.

Parent/Guardian Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Over-the-counter medication

I certify that I am the parent/guardian of the above named student. I request and authorize school personnel to dispense the above named over-the-counter-medication to my child as directed above and in accordance with the package directions.

Parent/Guardian Signature: _____ Date: _____

Prescription medication must be supplied in an original, labeled medication container. Most pharmacists will supply you with an extra, labeled medication container upon request. Over-the-counter medication must be supplied in the original container as purchased from the store.