THE CONNECTION SCHOOL
of Houston

AUTHORIZATION FOR DISPENSING MEDICATION

Student's Name: _____ DOB: _____

School Year: _____ Grade: _____

Condition for which medication is given: _____

Medication Name: _____ Dose: _____

Take Medication: ☐ By Mouth ☐ Via Inhaler ☐ Topical (cream) ☐ Injection ☐ Other: _____

To be given: ☐ Entire School Year - or - ☐ The following Dates: ___/___/___ to: ___/___/___

When to give: ☐ Routinely at the following times: _____ - or - ☐ As Needed

Special Requirements for Administration/Storage: _____

Known Food or drug allergies: ☐ YES ☐ NO If yes, please explain: _____

Prescriber's Name: _____Telephone: _____

Parent / Guardian Authorization	
I hereby request the school faculty/staff to administer the medication named above to my child. I understand that all medications must be in the original container, labeled with the child's name and date of birth, and with directions for administering the medication. Prescribed medication must also include the date and name of the prescribing physician. By signing below I release the school and its faculty/staff from all liability.	
Printed Name:	Phone:
Signature:	Date:

Faculty Review	
Medication was received from:	Date:
Medication was received by:	Date:
Initial Count (pills or tablets) or measurement (liquids)	

**For Self-Medication Administration see the Self-Medication Authorization Form*