



Medication Authorization Form

Please complete one form per medication, as needed.

If your student has **any prescription medications or over-the-counter medications that are not supplied by the school** that will need to be taken during the school day, or during an extended school event (including overnight field trips), please complete the following form.

Student Name: _____

Grade: _____

Date of Birth: ____/____/____

Medication Name: _____

Diagnosis/Reason: _____

Dosage: _____

Time(s) of day: _____

Beginning Date: ____/____/____

Ending Date: ____/____/____

PLEASE NOTE: All medications need to be brought to school in their original container and clearly labeled.

I give permission for Eastern Mennonite School staff to administer the above named medication to the student named above:

Parent/Guardian Name (print): _____

Parent/Guardian Name (signature): _____

Physician/ Provider Signature: _____

(Required if the medication is to be given longer than 10 working days, if the packages states "Consult Physician" or if there is a discrepancy between parents' instructions and label/ packaging instructions. Always required for Epi-pens and inhalers.)

Phone: _____

Date: ____/____/____

If you have any questions about this form, please contact the school at 540-236-6004.
School fax number: 540-236-6028