School Year 2024-2025

Turtle Lake School District
Medication Administration Authorization Form

Student Name: _____ Allergies: _____

Prescription Medications (to be completed by the provider)							
Medication	Dosage	Route	Frequency	Time(s)	Start Date	Stop Date	Reason for Admin.

School: _____ DOB:_____ Grade:_____

Over the Counter Medications							
Medication	Dosage	Route	Frequency	Time(s)	Start Date	Stop Date	Reason for Admin.

Parent/Legal Guardian Consent (needed for all medication administration at school):

Medication will be provided by the parent/guardian in its original container or prescription-labeled container.

I hereby give permission for school personnel to administer the medication(s) listed on this sheet to my child according to the practitioner and/or my instructions. I authorize them to contact the practitioner with questions or concerns. I further authorize the practitioner to render treatment to my child, as appropriate and necessary, from administering the medication.

Parent/Guardian Name: _____ Phone Number:_____

Signature: _____ Date:_____

Practitioner Information (needed for all prescription medication administration at school):

Practitioner Name: _____

Practitioner Signature:_____ Date: _____

Clinic: _____ Phone: _____