CUERO INDEPENDENT SCHOOL DISTRICT
Health Services

Physician Authorization for Medication Administration at School
(please complete for each medication)

______________________	______________	______________
student	birthdate	campus

Medication to be administered: ______________________________

Dosage: ______________________________
Route: ______________________________
Frequency/Time: ______________________________

Purpose/Diagnosis: ______________________________

Adverse Reactions: ______________________________

Discontinuation Date: ______________________________

Special Instructions: ______________________________
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______________________________ ______________
Physician Date

Parental Consent for Medication Administration

I, ______________________________, give consent for the school nurse to give my child the above listed medication, as prescribed.

______________________________ ______________
Parent/Guardian Date