Authorization to Administer Medication

Student Name: _____ DOB: _____

Grade: _____ Team: _____

To Be Completed By Health Care Provider

Diagnosis _____

Medication _____ Dose _____ Route _____ Time(s) _____

Recommendations_____ ICD Code _____

All medication should be given as close to the prescribed time as possible, however may be given up to one

No Yes