FRIENDSHIP HOUSE (815) 459-6552 OR FAX (815) 459-6554  
 MEDICATION AUTH0RIZATION FORM  
**According to state law: Only medication absolutely necessary for maintaining health shall be administered at school. *We require that all prescription and non-prescription medication be authorized by your child’s physician****.***IT IS OUR POLICY THAT ALL MEDICATION SHOULD BE ADMINISTERED IN THE HOME WHEN AT ALL POSSIBLE**. If prescription medication or non-prescription medication is to be administered at school, the physician must direct that prescription medication or non-prescription medication be give during school hours. The request must be on file with the office with both the physician and parent/guardian signatures directing the administration of the medication.

The parent/guardian must assume the responsibility for informing the school in writing of any changes in the child’s health or change in medication. If there is a change to the dosage or the medication, a new authorization form must be completed. The medication will be kept in the kitchen away from the reach of children with the exception of life saving medication e.g. Epi Pen; Inhaler, which will be kept in the child’s classroom cabinet with the first aid items away from the reach of children.

*ALL MEDICATION MUST BE BROUGHT IN TO SCHOOL IN THE ORIGINAL CONTAINER. YOUR CHILD’S NAME MUST BE CLEARLY MARKED ON THE BOTTLE.  
This form needs to be completed for EACH medication and any time there is a medication/dosage change*.  
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**To be completed by Parent/Guardian**:

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Child’s Name Teacher/Room

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date Parent/Guardian Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**To be completed by Physician:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Medication Time of Day Start Date End Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage Method to Administer

Reason for medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Possible side effects\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date Physician’s Signature