# Meadow Glade Adventist Elementary School

## Doctor's Authorization for Prescription Medication Administration

Student's Name_____Today'sDate_____

Date of Birth_____Grade / Room_____

**This portion of the form is to be completed by the student's physician.**

Name of Medication_____

Dosage_____ Route of Administration_____

Time of Day to be Given_____

Other Instructions_____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above. Medication may be administered by medically untrained school personnel.

Physician Signature _____ Date_____

Physician Name (print) _____

**This portion of the form is to be completed by the parent / guardian.**

I certify that I am the parent / legal guardian, of the above identified student and authorize the school to administer the above identified medication as indicated above.

**Parent Signature** _____ Date _____

**MGAES Phone 360-687-5121 / Fax 360-687-7166 / mgaes.org**