

**BRASHIER MIDDLE COLLEGE CHARTER HIGH SCHOOL  
AUTHORIZATION FOR MEDICATION AT SCHOOL**

(MUST BE SIGNED BY PARENT AND PHYSICIAN)

PLEASE PRINT

SCHOOL YEAR: \_\_\_\_\_

STUDENT'S NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

LEGAL GUARDIAN: \_\_\_\_\_ DAYTIME PHONE: \_\_\_\_\_

NAME OF MEDICATION: \_\_\_\_\_

REASON FOR GIVEN MEDICATION AT SCHOOL. (PLEASE BE SPECIFIC):  
\_\_\_\_\_

AMOUNT OF MEDICATION TO BE GIVEN: \_\_\_\_\_

TIME OF DAY MEDICATION IS TO BE GIVEN AT SCHOOL: \_\_\_\_\_

EXPIRATION DATE OF MEDICATION: \_\_\_\_\_

DATE TO *START* MEDICATION: \_\_\_\_\_

DATE TO *STOP* MEDICATION: \_\_\_\_\_

POSSIBLE SIDE EFFECTS: \_\_\_\_\_  
\_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

OFFICE PHONE #: \_\_\_\_\_

**PARENTS PLEASE READ CAREFULLY:**

I understand that all medication will be provided by me in the original container, clearly labeled with my child's name. I will notify the school if the medication is discontinued or the dosage has been changed. Permission is granted to the principal and/or school nurse to share this information with individuals who have responsibility for my child. The first dose will be given at home so that I can monitor adverse reactions. I give the school nurse and/or designee my permission to contact the above named Physician's office to request medical information concerning my child. I am responsible for replacing medication before the expiration date.

LEGAL GUARDIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_