# GST Multidistrict
## Authorization to Administer Medication

Child: ______________________________ Teacher: ______________________

Parent(s): ___________________________ Phone: ________________________

Address: _____________________________________________________________

*__MEDICATION__* *__DOSAGE__* *__TIME__* *__DIRECTIONS__*

_____________________________________________________________________

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COMMENTS/REASONS/SPECIAL INSTRUCTIONS:

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I AUTHORIZE ANY PERSON OR PERSONS DESIGNATED BY THE DIRECTOR TO ADMINISTER THE ABOVE MEDICATION TO MY CHILD, ____________________.

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PARENT'S SIGNATURE DATE

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*MEDICATION REQUIRED TO BE TAKEN AT SCHOOL WILL BE STORED IN THE OFFICE (UNLESS OTHERWISE SPECIFIED AND APPROVED) AND WILL BE DISPENSED BY DESIGNATED SCHOOL PERSONNEL ONLY.

*__NO MEDICATION, INCLUDING TYLENOL, IS DISPENSED WITHOUT PRIOR WRITTENPARENTAL CONSENT.__

*MEDICATION MUST BE CLEARLY LABELED WITH THE CHILD'S NAME.