AUTHORIZATION FOR ADMINISTERING MEDICATION BY SCHOOL PERSONNEL

WARRICK COUNTY SCHOOL CORP. 2024-2025 **4220-E**

I hereby authorize school personnel to administer as indicated:

Name_____Grade_____ Teacher_____

Rx number_____ Pharmacy_____

Name of medication_____ Dosage_____

Directions_____

Time to be given at school_____Doctor_____

Hours when medication is given at home_____

I understand that my signature attached, herewith, relieves the school personnel of any and all liability related to the administration of the prescribed medication.

Date_____ Signature of Parent/Guardian _____

Phone (H)_____(W)_____(C)_____

Medications administered by:

Name	Title		Initials

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug	X	X	X	X	X	X				X	X						X	X						X	X					X
Sept	X	X					X	X						X	X			X			X	X						X	X		X
Oct					X	X					X	X	X	X					X	X						X	X				
Nov		X	X		X				X	X						X	X						X	X			X	X	X	X	X
Dec	X						X	X						X	X						X	X	X	X	X	X	X	X	X	X	X
Jan	X	X	X	X	X						X	X						X	X	X					X	X					
Feb	X	X			X			X	X						X	X	X					X	X					X	X	X
Mar	X	X						X	X						X	X						X	X	X	X	X	X	X	X	
Apr					X	X						X	X						X	X						X	X			X
May			X	X						X	X						X	X					X	X	X	X	X	X	X	X	X

A= Absent X= No School 0= Not Given (comment on back) FT= Field Trip