



Department of Health & Rehabilitative Services

Authorization for Distribution of Medication

(Please write legibly)



Student Name: _____

Name of Medication or Prescription Number: _____

Amount of Medication to be given: _____

Times Medication is to be given: _____ Date medication should be discarded: _____

No prescription medicine will be administered at Providence School that is not in the original container. The bottle/package must be clearly marked with the name of the child, dosage, and time(s) to be administered. Any medication left at the end of the school year will be discarded after one week.

I release Providence School, the personnel, and New Life Christian Fellowship from any liabilities which might arise from the administration of the above listed medication.

Parent's Signature: _____ Date: _____

DATE	TIME	MEDICATION	DOSAGE AMOUNT	INITIALS	DATE	TIME	MEDICATION	DOSAGE AMOUNT	INITIALS

(8-8-02)



Department of Health & Rehabilitative Services

Authorization for Distribution of Medication

(Please write legibly)



Student Name: _____

Name of Medication or Prescription Number: _____

Amount of Medication to be given: _____

Times Medication is to be given: _____ Date medication should be discarded: _____

No prescription medicine will be administered at Providence School that is not in the original container. The bottle/package must be clearly marked with the name of the child, dosage, and time(s) to be administered. Any medication left at the end of the school year will be discarded after one week.

I release Providence School, the personnel, and New Life Christian Fellowship from any liabilities which might arise from the administration of the above listed medication.

Parent's Signature: _____ Date: _____

DATE	TIME	MEDICATION	DOSAGE AMOUNT	INITIALS	DATE	TIME	MEDICATION	DOSAGE AMOUNT	INITIALS

(8-8-02)