Augusta School

46839 Maple Leaf Place Sterling Virginia 20164
571-434-6200

Authorization for Medication

No medication will be given without **SIGNED** permission from the parent or guardian. In addition all medication must be accompanied by a Physician's Note stating name of medication to be given; specific dates to be given; dosage to be given; and times to be given.

Please complete this entire form.

Child's name: _____

Name of medication: _____

Amount of medication to be given: _____

Time(s) medication is to be given: _____

Dates medication is to be given: Begin on: _____ End on: _____

Reason medication is being given: _____

Reactions indication medication should be discontinued (call parent immediately): _____

_____

_____

By signing below, the Parent or Guardian releases Augusta School, its Officers, Administration, and Employees, from any claims and liability for administrating the above medication.

_____ _____

Parent / Guardian Signature Date

Date	Time	Name of Medication	Dosage Given	Signature of Administrator	Reaction / Comments