Augusta School

46839 Maple Leaf Place Sterling Virginia 20164

AUTHORIZATION FOR MEDICATION FORM

No Medication will be given without SIGNED permission from the parent or guardian. ***Please complete the entire form.***

Child's Name: _____
Name of Medication: _____
Amount of Medication: _____
Time(s) Medication is to be given: _____
Dates for Medication is be given: _____ to _____
Reason Medication is being given: _____
Reactions indicating 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	Medication	Amount of Dosage	Signature of administrator	Reaction/Error