



**Authorization for Administration of Medication**

**Individual orders for:**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Weight:** \_\_\_\_\_

*To be completed by the parent and signed by the parent and MD.*

MEDICATION	DOSE	ROUTE	TIMES TO BE ADMINISTERED	INDICATIONS	COMMENTS
Tylenol (acetaminophen)					
Advil (ibuprofen)					
Tums					

**Student's Physician Name:** \_\_\_\_\_

**Address and Phone no.:** \_\_\_\_\_

**MD Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_