Faith Baptist Elementary and Middle School
Bringing Glory to God Through Excellence in Education
Lichtenbrucher Strasse 17, 67661 Kaiserslautern DE

Authorization for the Administration of Medication

Parents/guardians requesting medication administration to their child shall provide the school with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child _____ Today's Date_____

Medication Name/Generic Name of Drug_____ Controlled Drug? YES NO (Circle one)

Condition for which drug is being administered:_____

Time of Administration _____ Start Date _____ End Date _____

Dosage_____Method _____

Specific Instructions for Medication Administration:_____

_____

Prescriber/Clinic Name _____ Phone Number _____

Parent/Guardian Authorization:

I request that medication be administered to my child as described and directed above. I hereby request that school personnel administer the above ordered medication. I have administered at least one dose of the medication to my child/student without adverse effects.

Parent/Guardian Signature_____ Relationship_____ Date _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

FBS Staff Only:
_____ Authorization form is complete **_____ Medication is appropriately labeled**
_____ Medication is in original container **_____ Date on label is current**

Person Accepting Medication (print name) _____ Date _____