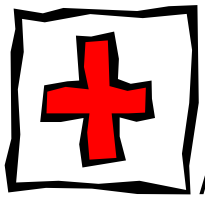

Albin Elementary School

Medication Authorization /Administration Form

Pam Shults, School Nurse * Phone 307-245-4160 * FAX 307-459-6035

Child's Name _____Grade _____Date _____

Medication Name _____

Dosage _____Time/Frequency _____

Reason for medication _____

Possible side effects _____

Special instructions _____

Estimated Termination Date _____
(All authorizations expire at the end of the school year.)

Physician prescribing _____

Physician's address _____Phone number _____

I request this medication be given to my child _____

as prescribed by my child's physician.

Parent/Guardian Signature _____Date _____