MURRAY SCHOOL DISTRICT
5102 S. Commerce Drive
Murray, UT 84107
(801) 264-7400

STUDENT MEDICATION AUTHORIZATION FORM

STUDENT INFORMATION:

_____
Student Name | Date of Birth | Grade

_____
Parent/Guardian | Home Phone | Work Phone

_____
Home Address | City/State | Zip Code

PHYSICIAN:

_____
Name of Physician Prescribing Medication | Office Phone

_____
Physician's Business Address | City/State | Zip Code

MEDICATION:

_____
Name of Medication | Dosage | Time(s) of Administration

Side Effects (if any): _____

_____

Procedure to follow in case of side effect/reaction: _____

_____

_____ _____
Physician Signature | Date

I give permission for school personnel to administer the medication identified above in the manner specified by the physician.

_____ _____
Parent/Guardian Signature | Date