Platte County R-3 School District

Medication Administration Authorization Form

I, _____ the legal parent/guardian of :

Student Name: _____ Grade: _____

give my permission to the Platte County R3 School District Superintendent (or designee) to administer the following medication to my child:

Beginning date: _____ Ending date: _____ Expiration:_____

Name of Medication: _____ For treatment of : _____

Dose: _____ Route: _____ Time of administration: _____

Change in medication:

Dose: _____ Route: _____ Time of administration:_____ Start date:_____

Pharmacy: _____ Telephone: _____ Prescribing physician:_____

I understand that any remaining medication must be picked up in person by parent/guardian prior to student dismissal on the last day of the current school year. I understand that if the medication is not picked up by this time, the medication will be disposed of. _____ (parent initial)

NOTE: Over-the-counter medications must be brought in the original, unopened container. The lowest dosage on the bottle will be given unless a Dr. order is received by the school district.

Date	Rx Number/Pharmacy	Number Received	Signature of Parent/Guardian	Witness