

Home of Fine Arts Connection Incorporated

Medical Authorization Form

Student Name _____ Date _____

Teacher's Name _____ Class _____

To be completed by Parent/Guardian

I authorize staff personnel to see that my child, _____
receives the medication listed below. I will not hold the personnel
responsible for giving this medication.

If it is PRN, it is prescribed by _____

(parent/guardian name – please print)

(phone number)

(parent/guardian signature)

(date)

Please list all medications that your child is taking at home:

(medication)

(dosage)

(route of administration)

(time/frequency)

Other recommendations: _____
