**MCS PARENT AUTHORIZATION**
**TO ADMINISTER MEDICATION**

Permanent Basis: ☐ As Needed: ☐ Today Only: ☐

Student's Name: ______________________________

Name of Medication: ______________________________

Name of Physician: ____________________ Prescription No. ____________

Exact Dosage to be Administered: ____________ Time to Administer: ____________

**DOES MEDICATION NEED TO BE RETURNED DAILY?** ________

Parent Signature: ______________________________ Date: ____________

Medication must come in its ***ORIGINAL CONTAINER***. You will receive daily notification of medication administered.

Please enclose a medication spoon, if necessary.

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