# DISCOVER AFTER SCHOOL
## MEDICATION AUTHORIZATION FORM

## DEAR PARENT / GUARDIAN,

Discover After School, Inc. needs to have permission from a medical provider and/or parent to administer medication to a student.

As the parent/guardian of the below-mentioned student, I give Discover After School permission to administer the medication indicated on this form. I will keep Discover After School aware of any changes in medication(s) or health concerns of my child.

**Please Note**: We do not administer any medication that does not have the prescription label or over the counter label on the container.

| **STUDENT FIRST & LAST NAME** | | DATE: |
|---|---|---|
| SCHOOL | GRADE | DOB |

| **NAME OF MEDICATION** | | NON-PRESCRIPTION OR PRESCRIPTION? |
|---|---|---|
| AMOUNT TO BE GIVEN | TIME TO BE GIVEN | ROOM TEMPERTURE OR REFRIGERATED? |
| REASON MEDICATION IS TO BE GIVEN | | CHECK IF NO LONGER NEEDED _____ |
| **NAME OF MEDICATION** | | NON-PRESCRIPTION OR PRESCRIPTION? |
| AMOUNT TO BE GIVEN | TIME TO BE GIVEN | ROOM TEMPERTURE OR REFRIGERATED? |
| REASON MEDICATION IS TO BE GIVEN | | CHECK IF NO LONGER NEEDED _____ |

| | |
|---|---|
| **Parent Name:** _____<br>**Parent Signature:** _____ | **Date:** _____ |
| **Staff Signature:** _____ | **Date:** _____ |