STARWOOD SCHOOLS

Weekly Medication Authorization

CHILD NAME:_____ CLASS: _____

Is Medication clearly labeled with child's name?	YES	NO
Does Medication need to be refrigerated?	YES	NO
Is your child able to go outside?	YES	NO

INSTRUCTIONS:

Name of Medication: _____
Dosage: _____
Date: _____

Any special notes or instructions: _____

_____

Please Note: Starwood Schools and its staff are not responsible for any side effects, complications, or even any fatality arising as a result of administering medicine as noted by you in the instructions.

***No eye, ear, or nose drops will be administered.**
****Parents are responsible for picking up medication at the end of each day.**
*****NO NARCOTICS**

Parent's Printed Name: _____

Parent's Signature: _____

Date: _____

(Medication will only be administered if in its original bottle and not expired.)

NEW FORMS MUST BE FILLED OUT EACH WEEK

DATE	NAME OF MEDICATION	AMOUNT	TIME GIVEN	STAFF SIGNATURE