Clinton Community Schools
Medical Authorization Form

Name of Student: _____Date of Birth_____

Known Medication Allergies:_____

Name of Medication	1)	2)	3)	Tylenol/Motrin (Circle one if necessary)
Amount of medication				
Time of Administration				
Route of Administration				
Possible Side Effects				
Special Concerns or Comments				

Legal Prescriber's Printed Name_____

Prescriber's Signature_____Date_____

Address_____Telephone_____Fax_____

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1) **No medication will be given without an order signed by the legal prescriber.**
2) **All prescription bottles must be labeled by the pharmacy with a current date, the name of the student, name of medication, strength of medication and time to be given.**
3) **All non-prescription medication must come to school in its original packaging.**
4) **Any change in dosage or addition of new medication must be accompanied by written legal prescriber's statement.**

I hereby request that my student be administered his/her medication by the school personnel authorized by the principal/supervisor. I understand that the medication will be administered as per the instructions of my above named physician. I will notify the school of changes or discontinuation of this medication(s).

Parent/Guardian Signature _____ Date_____

Clinton Elementary Nurse – Kristi Cymes Phone 517-456-6504 ext. 214 Fax 517-456-8201