Medicine Authorization Form

Name of child _____

Name of Medicine_____

Dosage and Frequency_____

Dates to be administered _____

I am authorizing the staff at Valor Preparatory Academy to administer the above named medication to my above named child:

Parent/Guardian signature _____

Check appropriate box below:

- ❑ I would like remaining medicine returned to me after the dosage period has ended.
- ❑ Dispose of medicine after the dosage period has ended.