

COMMISSION SCOLAIRE EASTERN SHORES
EASTERN SHORES SCHOOL BOARD

AUTHORIZATION FORM
For the Administration of Prescribed Medication

I, _____, authorize _____
(name of parent) (name of staff member)

or his or her substitute, to give my child _____
(name of student)

Medication at school as prescribed by the doctor.

Name of medication: _____

Time(s) of day to be administered: _____

Dosage (please be **very** precise): _____

I realize that it is my responsibility to immediately advise the school of any change to the above information.

Parent's Signature

Date