MEDICATION AUTHORIZATION AND DAILY MEDICATION LOG

Name: _____Grade: _____ Teacher _____

Medication and Dosage: _____

Frequency and Time: _____ Date Begun: _____ Date to End_____

Prescriber's Name: _____ Phone Number: _____

Parent's Name: _____Phone Number: _____

I hereby authorize University School of Jackson to dispense the above medication as indicated on this authorization form.
Parent/Guardian Signature: _____Date: _____

Date	Time	Dosage	Initialed By	Date	Time	Dosage	Initialed By

Parent's Signature & Date when Medication is picked up: _____