Park View Pediatrics
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Office: (303)972-2000 | Fax: (720)245-2690

Authorization to Give Medications at School from Provider & Parents

Center Name/School _____

Child's Name _____DOB_____

Name of Medication _____

Medication Dose _____Route_____Time_____

Start Date _____End Date_____

Purpose of Medication_____

Special Instructions _____

Provider's Printed Name_____

Provider's Signature _____ Date_____

Parent/Guardian Authorization to Give Medication

_____ has my permission to administer
(Name of Center/School)

_____to my child
(Name of Medication)

_____ starting on _____
(Child's name) (Date)

and ending on _____ as prescribed by the provider.
(Date)

_____ _____
(Signature of parent) (Date)