MURRAY SCHOOL DISTRICT

5102 S. Commerce Drive Murray, UT 84107 (801) 264-7400

STUDENT MEDICATION AUTHORIZATION FORM

Student Name	Date of Birth	Grade
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Parent/Guardian	Home Phone	Work Phone
Home Address	City/State	Zip Code
PHYSICIAN:		
Name of Physician Prescribing Medication		Office Phone
Physician's Business Address	City/State	Zip Code
MEDICATION:		
Name of Medication	Dosage	Time(s) of Administration
Side Effects (if any):		
Procedure to follow in case of side effect/reaction	on:	
Physician Signature	Date	
I give permission for school personnel to manner specified by the physician.	o administer the medication	on identified above in the
Parent/Guardian Signature	 	