Authorization to Dispense Prescription Medication

I authorize Academy at the Lakes to assist with dispensing the following prescribed medication to my child. Please print all information except signatures.

Date _____

Student name_____

Name Medication_____

Doctor_____

Dosage_____

Time(s) _____ _____ _____

Physician Signature_____

Amount counted #_____to Academy at the Lakes by

Parent Signature_____

Amount counted by Academy at the Lakes staff member

#_____Signature _____Date_____

Authorization to Dispense Over the Counter Medication

I authorize Academy at the Lakes to dispense the following OTC medication to my child, with my consent at the time of administration.

Date _____

Student name_____

Medication _____

Dosage_____

Time(s)_____ _____ _____

Amount counted #_____to Academy at the Lakes by

Parent Signature_____

Amount counted by Academy at the Lakes staff member

#_____Signature _____Date_____