Epiphany School
Miami, Florida
Authorization for Medication

Name of Student _____

Parental Permission (To be completed by Parent or Guardian for non prescription and prescription medicine)

Date _____

My permission is hereby granted to school clinic personnel to administer prescribed medication to my _____ (relationship)

Name of Student _____

Signature of Parent/Guardian _____

(This part to be completed by Physician for Epi Pen, or any prescription medicine)

Date _____

Physician _____

Address _____

Phone _____

Diagnosis _____

Medication and Dosage Prescribed _____

Side Effects _____

Purpose of Medication _____

Direction for Administration by School Clinic Personnel _____

Signature of Physician _____