Authorization and Permission for Administration of Medication
KORE Academy

2015-16 School Year

(Please complete one form for each of your student's medications.)

PARENT AUTHORIZATION:

Student's Name: ____ DOB: ___________________

Allergies: ____

Reason for medication or diagnosis: ____

Medication: ____

Dosage: _________________________ Time of Day to be Administered: __________________________

Indicate the reason for administration of an "as needed" over- the- counter medication: _____________

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PARENT/GUARDIAN STATEMENT

I, the undersigned Parent/Guardian of the student named above, request that a KORE staff/volunteer member administer the above medication to my student per Physician instructions. I agree to furnish the necessary prescribed medication and agree to notify KORE Academy immediately of any changes. I understand the KORE Academy Policy on Medication Administration is readily available for me to read. I sign this voluntarily and with full knowledge of its significance.

X ____ ___/___/______

(Parent/Guardian Signature) (Date)

____

(Printed Name)

Home Phone: ____________________ Work: ____________________ Cell: _________________

KORE Academy Parent Authorization and Permission for Administration of Medication Form