**North Wall Schools**

Medical Treatment Authorization Form

**Child's Name** ______________________________________________

Reason for Medication ______________________________________________

Name of Medication ______________________ Amount __________________

Frequency ________________________ Times Given at Home ______________

Method of Administration at North Wall Schools ______________________

Amount __________________________ Times to be Given ________________

**I authorize North Wall Schools to give the above medication(s) and/or treatment to my child.**

Signature ______________________________________ Date ____________

(Parent)

Record of Medications Given (to be filled out by the person who gives the medication):

| Date | Time | Staff Signature | Date | Time | Staff Signature |
|---|---|---|---|---|---|
| ______ | ______ | ______________ | ______ | ______ | ________________ |
| ______ | ______ | ______________ | ______ | ______ | ________________ |
| ______ | ______ | ______________ | ______ | ______ | ________________ |
| ______ | ______ | ______________ | ______ | ______ | ________________ |
| ______ | ______ | ______________ | ______ | ______ | ________________ |


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|---|---|---|---|---|---|
| ______ | ______ | ______________ | ______ | ______ | ________________ |
| ______ | ______ | ______________ | ______ | ______ | ________________ |
| ______ | ______ | ______________ | ______ | ______ | ________________ |
| ______ | ______ | ______________ | ______ | ______ | ________________ |
| ______ | ______ | ______________ | ______ | ______ | ________________ |