

**St. Edward-Epiphany School**  
**MEDICATION AUTHORIZATION**  
10701 West Huguenot Road  
Bon Air, Virginia 23235  
(804) 272-2881  
FAX (804) 327-0788  
WWW.SEESCHOOL.COM

Parent/Guardian:

Please complete part A. Have your child's physician/clinic complete Part B. Bring the completed form, with the medication in the original container, to the Health Office. **Medication should not be sent to school with your child.** At least one dose of medication should be given at home prior to use at school.

Thank you for your co-operation in this matter.

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**Part A**

I authorize the school representative to give my child, \_\_\_\_\_, Grade \_\_\_\_\_, The following medication as prescribed by his/her physician/clinic. Should there be any question, please reach me at my home phone \_\_\_\_\_, or my work phone \_\_\_\_\_.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**Part B**

Please administer to \_\_\_\_\_, the following medication  
During school hours:

Medication: \_\_\_\_\_

Reason: \_\_\_\_\_

Strength: \_\_\_\_\_

Dosage: \_\_\_\_\_

Time: \_\_\_\_\_

Start Date: \_\_\_\_\_

End Date: \_\_\_\_\_

MD Name (print): \_\_\_\_\_

Date: \_\_\_\_\_

MD Signature: \_\_\_\_\_

Phone: \_\_\_\_\_