Academy360
lower school

School Year 24 -25

PHYSICIAN'S MEDICATION AUTHORIZATION FORM

Student's First Name: _____ Student's Last Name: _____

DOB:_____ Allergies:_____

The school nurse at Academy360 is to administer the following dosage of medication(s):

	Medication	Dose	Route	Time	Reason
1					
2					
3					
4					
5					

Physician's Signature: _____ Date: _____

_____

Parent/Guardian Name (print) **Signature** (consent to administer) **Date**

Physician's Office Stamp: