THE MASTER'S ACADEMY
Inspiring Faith & Learning
954.434.2960

AUTHORIZATION FOR MEDICATION / TREATMENT

Student's Name:_____ Grade:_____

Allergies:_____

_____

Diagnosis:_____

_____

_____

_____

MEDICATION	DOSAGE & ROUTE	FREQUENCY	SPECIFIC TIME	SPECIAL INSTRUCTIONS/ SIDE EFFECTS

_____ _____

Physician's Name (Printed) Physician's Signature

_____ _____

Physician's Office Number Date Completed

PARENTAL PERMISSION FOR MEDICATION / TREATMENT

My permission is given, for designated Clinic personnel, to administer to above prescribed medication to my child.

_____ _____

Name of Parent / Guardian (Printed) Signature of Parent / Guardian

_____

Date Signed