



Pocatello/Chubbuck School District #25 Head Start

330 Oakwood Drive, Pocatello, ID 83204 (208)233-6606

www.pochs.org

Authorization to Administer Medication

Name of Student: _____ Date of Birth: _____

Part I: **Physician's Statement**

Name/type of medication:	_____
Dosage or amount to be given:	_____
Duration (week, month, indefinite, etc.)	_____
Anticipated reaction to medication (please include any expected side effects or symptoms)	_____ _____ _____

Physician's Name: _____

Physician's Signature: _____ Date: _____

Part II: **Parent's Request/Approval**

The following individuals are approved to administer medication to my child:

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

I hereby request and give my permission for the above named school personnel to administer the medication prescribed on this form to my child while at Head Start.

Parent's Signature: _____ Date Signed: _____

Parent's Name (printed): _____