Austin Discovery School

Authorization to Dispense Medication

Student Name ______________________________**Date of Birth** _____________

Teacher ____ **Grade** _________

Address ____

Street Apt # City Zip Code

Description of and *specific* directions for student medication (includes dates and times medication is to be dispensed.)

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I hereby authorize Austin Discovery School personnel to administer the above medication(s) to the student named on this form. I understand that neither Austin Discovery School nor its personnel assume responsibility for any adverse effects the medication may have on the student.

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Signature of Parent/Guardian **Date**