AUTHORIZATION TO ADMINISTER NUTRITIONAL SUPPLEMENT

It is strongly encouraged that a nutritional supplement be given before and/or after school hours. This authorization is to certify that it is necessary that this nutritional supplement be given during school hours. **Additional information may be requested by the school to document the name, type, dosage and any known side effects.**

PARENTAL CONSENT

Name_____Birthdate_____

School_____ Year_____ Grade _____

Parent/Guardian _____

Phone: (Home)_____ (Work)_____

(Cell) _____ (Pager)_____

I give permission for my son/daughter to receive a nutritional supplement during school hours. I give permission to share this information with appropriate school personnel. I will:

- Deliver the supplement to the school office in its **original container or packaging**
- Maintain a sufficient supply of the supplement at school
- Obtain a new authorization if any changes occur with this supplement
- Pick up any unused supplement

_____ _____

Parent/Guardian Signature Date

HEALTH CARE PROVIDER'S AUTHORIZATION

I am in agreement with the use of the following nutritional supplement for _____

Student's Name

PLEASE LIST ONE SUPPLEMENT PER FORM

Supplement Name *(List ingredients)*	**Dosage** *(mg/cc/tsp./gtt)*	**Form** *(tab/cap/powder/etc.)*	**Time *** *a.m./p.m.*	**Possible Adverse Side Effects**

**** NOTE: Administration of supplement will be done during non-instructional time (recess, lunchtime, etc.)***

I believe that it is necessary to administer this nutritional supplement during school hours. The above authorization shall remain in effect through the end of the current school year unless discontinued or changed by me or the parent/guardian withdraws the request in writing.

Health Care Provider's Name _____ Phone _____

(Please Print)

Health Care Provider's Signature _____ Date _____

(No Stamp)

Page two for school use only

For School Use Only

- Date Received: _____

- Name of Person(s) who will administer the supplement:

_____ _____ _____

- Approved by: _____ _____
  Signature of Principal *Date*

- _____ Referred for administrative review. Send to School District Nurse with your concerns about this authorization.