St. Brigid School

Excellence Faith Community

MEDICATION ADMINISTRATION SLIP

(For doctor prescribed and over the counter medications or OTC)

Student Name: ____ Date: ______________________

Age: ________ Grade: ________ Teacher: ___________________________

NAME OF MEDICATION: ____

DOSAGE: ____

TIMES TO BE TAKEN: ____ (indicate AM or PM)

Why is the student taking this medicine? (Please explain): ____

____

How long will the student need to take medication at school? (Please explain: _______________________

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Other information we should know: ____

*****All PERSCRIPTION MEDICATION sent to school MUST** be **in the ORIGINAL CONTAINER or box or have the pharmacist put a prescription label on the medication bottle/container itself. This label MUST include the NAME, DOSAGE INSTRUCTIONS, DOCTOR'S NAME and DATE. All OTC (over the counter) medications must be in the ORIGINAL CONTAINER and labeled plainly with student NAME. *****

I acknowledge and give permission for Licensed (RN) or trained unlicensed school personnel (if RN is unavailable) to administer the above medicine as per the health care provider's instruction. In addition, information regarding this medication may be shared with appropriate school personnel for need-to-know purposes.

Parent Signature: ____ Date: ______________

Best phone number where you may be reached: ____

Revised: 10/2022