

Authorization for Medication Administration in School

Student Name: _____ DOB: _____ Grade: _____

TO BE COMPLETED BY PRESCRIBING PHYSICIAN

Medication: Prescription Over the Counter

Name of Medication _____ Dosage _____ Route _____ Time(s) to Be Taken _____

Diagnosis or reason for medication: _____

If given PRN, specify the minimum length of time between doses: _____

Possible medication side effects: _____

Restrictions or Special Instructions: _____

I request and authorize the above-named student be administered the above medication in accordance with the instructions indicated above from _____ to _____ (not to exceed current school year). (date) (date)

Date

Physician Name (please print)

Telephone Number

Physician's Signature

OFFICE
STAMP:



TO BE COMPLETED BY THE PARENT / GUARDIAN

- I give my permission for this medication to be administered to my child at school. The school has my permission to call the physician with any questions regarding the medication.
- I understand and acknowledge that any medication administered to my child during school will more than likely not be administered by a registered nurse or other medical professional. In consideration of the school administering medication to my child pursuant to this authorization, I hereby release and hold harmless the school, the Archdiocese of St. Louis, and their employees, agents or representative, from any liability that may arise from administering medication to my child.
- All medication supplied must be brought to school in its original container with instructions as noted above by the physician.

Date

Parent/Guardian Name (Print)

Parent/Guardian Signature

Please ask the pharmacist for an extra-labeled bottle for school. Thank you!