

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!