

Authorization for Medication Administration in School

Student Name: _____ DOB: _____ Grade: _____

TO BE COMPLETED BY PRESCRIBING PHYSICIANMedication: Prescription ☐ Over the Counter ☐

<u>Name of Medication</u>	<u>Dosage</u>	<u>Route</u>	<u>Time(s) to Be Taken</u>
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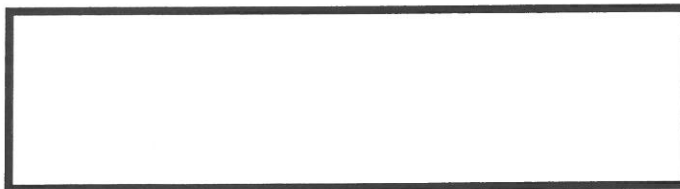
Diagnosis or reason for medication: _____

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!**