

Authorization for Medication Administration in School

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

TO BE COMPLETED BY THE PRESCRIBING PHYSICIAN

Medication: Prescription  Over the Counter

<u>Name of Medication</u>	<u>Dosage</u>	<u>Route</u>	<u>Time(s) to Be Taken</u>
_____	_____	_____	_____

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)

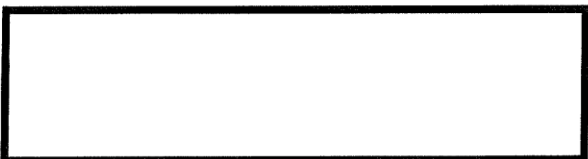
\_\_\_\_\_  
Date

\_\_\_\_\_  
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!**