

Authorization for Medication Administration by School Personnel

To: Jeananne Bloudek
Principal

Of: St. James Catholic School
School Name

Student Name: _____ DOB: _____ Grade: _____ Teacher: _____

I am giving school personnel permission to administer medications to my child per the following:

Parent or Physician please complete:

Medication: _____ Non Prescription

Dose (how much): _____ Prescription Rx number: _____
Tablets requiring cutting should be cut by the parent before being sent to school. Liquid medication requires dosage spoons, available from your pharmacist, to be supplied by parent.

Route: (circle one)
By: Mouth Ear Eye Nose Skin Inhalation

Time to be given @ school: _____

Duration: Start Date: _____ End Date: _____

Reason for Medication: _____

Special Instructions: _____

I understand I am responsible to provide this medication and maintain the supply as needed. I understand I am responsible to notify the school in writing of any changes. Parents are required to pick up all unused medication by the last day of school. All medication left at the school will be discarded.

Parent/Guardian Signature: _____ Date: _____

This authorization applies only to the medication listed above and for the duration of treatment or school year. This also authorizes an exchange of information, as necessary, between appropriate school personnel, and/or my child's health provider.

Physician Direction

(Required in writing or on pharmacy label for all prescription medication.)

I have prescribed the above medication for the student whose name appears at the top of this form. Instructions in the box are accurate.

Special instructions including adverse reactions and action required: _____

Physician's Name (Please Print)

Address

Physician's Signature

Phone #

Effective Date

ALL MEDICATION MUST BE IN ITS NEWEST ORIGINAL CONTAINER WITH ACCURATE LABEL.