APPENDIX 1

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 _____ (date) to _____ (date) (not to exceed current school year).

_____ _____

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!

Parental Consent for Student to Carry and Self Administer Medication
Parent Authorization / Student Contract

Student: _____ **DOB:** _____

School: _____ **Grade:** _____

My child may carry with him/her and self-administer his/her own medication. I realize that the school is not responsible for the benefits or consequences of the medication. The school bears no responsibility for assuring that the medication is taken. I also understand that if my child abuses the policy of carrying his/her medication, the medication will be confiscated and the privilege will be taken away.

Name of medication: _____

Reason for taking medication: _____

My child has _____ **allergies.**

Student Contract

( ) I plan to keep the above named medication with me at school rather than in the school office.
( ) I agree to use this medication in a responsible manner, in accordance with my physician's orders.
( ) If this is an inhaler, I will notify the school office if I am having more difficulty than usual with my asthma.
( ) I will not share my medication with others.

Student's Signature: _____ Date: _____

Parent/Guardian Authorization

This contract is in effect for the current school year unless revoked by the physician or my student fails to meet the above safety contingencies.

( ) I have returned an Action Plan and/or Medication Administration Authorization form to the office/nurse.
( ) I agree to see that my child carries his/her medication as prescribed, that the container contains medication, and the date is current.
( ) I will review the status of my child's medication with my child on a regular basis.

If my child uses an inhaler or has an epinephrine auto-injector, I will provide a back-up spare to be kept in the school office. _____ Yes _____ No

Parent/ Guardian's Signature: _____ Date: _____

Prescribing Physician

In my opinion, this student shows capability to carry and self-administer the above medication.

_____	_____	_____	_____
Physician Signature	Print Name	Telephone	Date

Office stamp