

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)

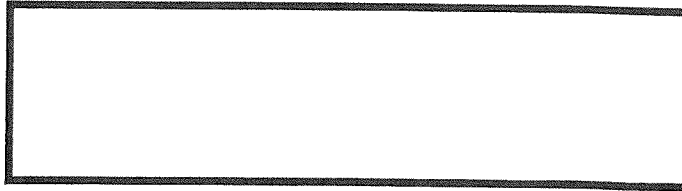
_____ Date

_____ 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!

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

