St. Joseph School
Authorization for Administration of Medication
2017-2018

Student Name: _____

Parent/Guardian: _____ Daytime Phone#_____

I (We) as parent/guardian of the above named student authorize the personnel of St. Joseph's School to give my child the following **non-prescription medication** should it be necessary. Dosage instructions from the bottle/container will be followed, unless otherwise specified by parent.

Please indicate the following that apply:

1. Ibuprofen(Motrin, Advil) _____ 2. Tylenol (Acetaminophen) _____
3. Tums _____4. Cough Drops _____ 5. Other_____

I (We) as parent/guardian of the above named student authorize the personnel of St. Joseph's School to give my (our) child the following **prescription medication(s)** should it be necessary. I (We) understand that all prescription medications will be sent in its ***original*** container with a proper label that includes: name of student, name of medication, dosage, route and frequency of administration, name, address and phone number of pharmacy, name, address, and phone number of prescribing physician. Also include reason for administration and possible side effects. I (We) give permission for appropriate school personnel to contact either the prescribing physician and/or the pharmacy it necessary.

Name of Medication(s)_____

Medical Management Plan? Yes No
(Required for asthmatic, anaphylactic and diabetic medications)

I (We) understand that if this form is not signed and returned to the school office, my child will not be given any medication at school. I (We) understand that all medications will be turned in to and stored in the office, unless a Medical Management Plan has been completed granting my (our) student permission to carry emergency medications on their person. I (We) accept ultimate responsibility for monitoring the effects and possible adverse reactions of these medications on my (our) child. I (We) therefore release St. Joseph School and its employees from all liability relating to the administration of non-prescription and/or prescription medication to my (our) child.

_____ _____
Parent/Guardian Signature Date

Medication Administration Log (office use only)

Date/Time	Medication/Dosage	Reason	Administered by