St. Joseph Catholic School

Authorization for Administration of Prescription Medication at School

Student Name _____ Grade _____ DOB _____

Name of Medication _____

Dosage _____ Route _____ Time _____

Special Instructions: _____

Possible Side Effects: _____

_____

Emergency Procedure in Case of Serious Side Effects: _____

_____

_____

Start Date: _____ End Date: _____

I (we) as parent/guardian, request and authorize that the above-named student be administered/provided the medication listed above in accordance with the instructions indicated. I (we) certify that the medication provided is the medication on the Prescription. I (we) understand that monitoring the side effects and possible adverse reactions of the medication remains my (our) responsibility. Therefore I (we) release St. Joseph Catholic School and its employees from all liability relating to the administering of the medication to the above-named student. I (we) give permission to share pertinent medical information with appropriate school personnel, the medical prescriber, and/or the pharmacy if necessary.

_____ _____ _____

Parent/Guardian Signature Date Phone #

Please Note:

1. ***Medication must be sent to the school in its original container and be kept in the school office.***
2. ***Separate authorization forms should accompany each medication.***
3. ***The first dose of a new prescription should be given at home to observe for any adverse reactions.***

Date	Time	Medication/Dosage/Route	Reason	Admin By