APPENDIX 1 4.1

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!