ST. JOSEPH
CATHOLIC SCHOOL

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name:_____ Birth Date: _____

School:_____ Grade: _____

THIS PORTION TO BE COMPLETED BY THE PHYSICIAN/DENTIST

Name of Medication	Dosage	Methods of Administration	Time of Day to Be Taken

If given in prn, specify the length of time between doses _____

Inhaler:_____
Indicate if student must carry on his/her person

Epi-Pen:_____
Indicate if student must carry on his/her person

Possible side effects of medication _____

Emergency procedure in case of serious side effects _____

☐I request and authorize that the above-named student be administered the above-identified medication in accordance with the instructions indicated above from _____ to _____(not to exceed current school year) as there exists a valid health reason, which makes administration of the medication advisable during school hours.

_____ _____
Date of Signature Physician/Dentist Signature

Telephone Number: _____ Name:_____
Print or Type

Please Note: If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request/authorize the school to administer medication to the above identified student in accordance with the doctor's instructions for the period from_____to_____(not to exceed current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner.
Permission to carry inhaler and/or Epi-Pen (please circle)

_____ _____
Date of Signature Parent/Guardian Signature

Telephone number:_____(primary)_____(other)