St. Mary Catholic Schools
Grades P3-12

# Medication Authorization Form

Form is to be used for one medication only. Each medication requires a separate form. All portions of the medication form must be completed before medication can be administered by trained school staff. Form needs to be filled out completely or it will be returned and medication will not be able to be given.

**Name of Student:** ________________________ **D.O.B.:** ____________ **Grade:** ____________

**School:** ________________________ **Name of Medication:** ________________________

**Dose:** ____________________ **Time(s) to be given:** 1. __________ 2. __________ 3. __________

**Method:** *(please circle)* Oral Inhaled Injectable Topical Eye Ear Other: ______________

**Give:** *(please circle)* Daily or As Needed **Dates to be given:** From: __________ To: __________

**If medication is to be given "As Needed", write the circumstances for which it should be used:** ______________

________________________________________________________________

**Comments:** ________________________________________________________

________________________________________________________________

**Parent / Guardian Consent:** *Complete for ALL Medication / Procedures at School*

- I request and authorize that school staff administer this medication or perform this procedure at school.
- I will supply medication in its original, updated, properly labeled container (an extra bottle can be requested from the pharmacy)
- This authorization is for the entire school year unless otherwise indicated.
- I will obtain a new physician's order and notify the school in writing for any changes.
- I authorize trained school staff to exchange information verbally or in writing with my child's physician regarding this medication/procedure or conditions for which it is prescribed.
- I understand that all medication is to be transported to and from school by parent/guardian.
- I agree to hold St. Mary Catholic Schools, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- My signature indicates that I have fully read and understand the above information.

***ASTHMA INHALERS:*** This student is capable of self-administration and may carry inhaler **Circle:** YES or NO
***EPI PENS ONLY:*** Student may self-carry epi-pen **Circle:** YES or NO

**Signature of Parent/Guardian:** ______________________________ **Date:** ________________

**Daytime Telephone Number:** ______________________________

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**Physician Authorization:** *Required for all Prescription Medication/Food Supplements/Over-the-Counter Medications that exceed the recommended packaging dose. Required for treatments or procedures needed to be done at school.*

***ASTHMA INHALERS:*** This student is capable of self-administration and may carry inhaler **Circle:** YES or NO
***EPI PENS ONLY:*** Student may self-carry epi-pen **Circle:** YES or NO

The above medication is to be administered during the school day. I understand that medication/treatment will be given by non-medically licensed staff that has been trained to do so. Further written instruction will follow from me if the drug is to be discontinued or the dosage or administration time is changed from these instructions.

**Symptoms/Side Effects of Medication:** ________________________________________

________________________________________________________________

**Health Care Providers Signature (no stamp):** ______________________________ **Date:** ____________

**Name of Physician (printed):** ______________________________ **Telephone Number:** ______________

**Physician Fax Number:** ______________________________

Last Revised 04/25/15