

Authorization for Administration of Medication at School

Student Name _____ Birth Date: _____

Blessed Sacrament School _____ Grade: _____

THIS PORTION TO BE COMPLETED BY PHYSICIAN/DENTIST/PROVIDER

<u>Name of Medication</u>	<u>Dosage</u>	<u>Route</u>	<u>Time of Day</u>
_____	_____	_____	_____

Please give length of time between doses: _____

Inhalers: _____

(Indicate if student must carry on his/her person)

Possible side effects of medication:

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

_____ Date of Signature

_____ Parent Provider 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, route, and time to be given.

.....
THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request/authorize the school to give medication to my student in accordance with the health care provider's instructions written above. I understand that unlicensed staff may be assigned to provide medication to my student, and I accept ultimate responsibility for monitoring the effects of this medication.

Permission to carry inhaler ____ Yes ____ No

Permission to self-administer medication ____ Yes ____ No

_____ Date _____ Parent/Guardian Signature _____ Phone # _____ Home _____ Work _____

OVER →

Competency Statement

I, _____ have determined
(Parent/Guardian Name)

Blessed Sacrament School Staff competent to give or apply medication to my child(ren). I understand that Child Care Center and Preschool Directors have the responsibility to assess the ability of staff to give or apply medication safely and may give medication to my child(ren).

Date

Signature of parent/guardian