Authorization for Administration of Medication at School

Student Name _____ Birth Date: _____

Blessed Sacrament School Grade: _____

THIS PORTION TO BE COMPLETED BY PHYSICIAN/DENTIST/PROVIDER

Name of Medication	Dosage	Route	Time of Day
_____	_____	_____	_____

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

_____ Name: _____
Telephone Number (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

_____ _____ Phone # _____
Date Parent/Guardian Signature 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