***Authorization for Administration of Medication at School***
***2019-2020***

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 2019-20 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

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## *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