St. Mary's High school

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

| A. TO BE COMPLETED BY THE PARENT OR GUARDIAN: | |
|--|--|
| on as prescribed below by our lice roperly labeled, original contai | Date of Birthensed health care prescriber. The ner from the pharmacy. the absence of the school nurse, will |
| Please Print Na | ame |
| City State | Zip |
| Work Telephone No. | Date |
| B. TO BE COMPLETED BY THE LICENSED HEALTH CARE PRESCRIBER: ***I request that my patient, as listed above, receive the following medication: Medication: Diagnosis: | |
| Route of Duration | Administration: of Treatment: |
| Name of Licensed Prescriber & Title (please print name) Prescriber's Signature | |
| Phone No. | Date |
| C. SELF MEDICATION RELEASE FORM ** NOTE: This section must be signed, in addition to the above District Medication Form, for those students who request permission to carry their own medication on campus or keep this medication in a P. E. locker. (child's name) has been instructed in the proper use of the following medication procedures: | |
| she has been instructed in and u trated to me that they can self | to keep same in his/her locker or p.e. inderstands the purpose and appropriate -administer the medications listed tly at school/school sponsored |
| | Grade In as prescribed below by our lice roperly labeled, original contain designated person in the case of Please Print Na City State Work Telephone No. LICENSED HEALTH (Ove, receive the following means) Prescriber's S Phone No. Prescriber's S Phone No. EDICATION RELEASE above District Medication Form, for those is locker. instructed in the proper use of the medication on his/her person or size that they can self the this medication independent |