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:

Child's Name_____ **Grade**_____ **Date of Birth**_____

- I request that my child receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the **properly labeled, original container** from the pharmacy.
- I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication.

_____ _____

Signature (Parent or Guardian) **Please Print Name**

_____

Address City State Zip

_____ _____ _____

Telephone No. 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:_____

Dose:_____ Frequency:_____ Route of Administration:_____
Time:_____ Duration of Treatment:_____

Possible Side Effects and Adverse Reactions (if any): _____

_____

_____ _____

Name of Licensed Prescriber & Title (please print name) **Prescriber's Signature**

_____ _____

Address City 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:

_____

We request that he/she be permitted to carry the medication on his/her person or to keep same in his/her locker or p.e. locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.

☐ ** I attest that this student has demonstrated to me that he/she can self-administer the medications listed safely and effectively and may carry and use this medication independently at school/school sponsored activities with no supervision by school staff.

_____ _____

Prescriber's Signature Parent's Signature