

Diocese of Joliet

MEDICATION AUTHORIZATION

2010-2011

If at any time during the school year it becomes necessary for a student to take medication (either prescribed or over the counter medicine) during the school day, this parent/guardian request form to administer the medication to the student must be completed and on file in the principal's office. The pharmacy label can serve as the written consent of the doctor.

I request that the medication described below be administered to my child at the times specified during the school day. I will provide the Principal/school nurse with this medication in a container provided by the pharmacist. I understand that this medication will be administered to my child only by a school nurse, the principal, or office personnel, and that the medication will be kept secure in a locked cabinet or refrigerator. I understand that this consent is valid for one year and must be renewed annually or whenever there is a change in medication.

Student's Name _____ Grade/Room # _____

_____ Prescription ___ Over-the-Counter
Name of Medication

_____ Time to Administer _____
Days Medication to be Given

_____ Refrigeration Required? _____
Dosage

Purpose of Medication: _____

_____ Physician's Name _____ Physician's Phone

_____ Pharmacy _____ Prescription Number

This medication is to be given to my child only until: _____

_____ Parental/Guardian Signature _____ Phone _____ Date