Saint Catherine of Siena School

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AUTHORIZATION FOR MEDICATION ADMINISTRATION

Both a licensed **prescriber** and a **parent/guardian** must complete and sign this form before prescription medication can be dispensed at school.

Student: ____

DOB ______________________________ Grade _________________

PRESCRIBER AUTHORIZATION

Must be completed and signed by a licensed prescriber

Medication: ____ **Dosage** ____________________

Route ____________ **Frequency** ______________________

Time(s) of administration at school _________________________

Specific instructions:
____

Possible side effects:
____

Diagnosis/Reason for medication:
____

Allergies:
____
_

Significant medical concerns/conditions:
____

Signature of licensed prescriber ____

Date ____________________ **Print name**______________________________________

Title _____________________ **Phone** _____________________________

PARENT/GUARDIAN AUTHORIZATION

My child currently takes the following *additional* medication:

____

____

* I give consent for the school nurse (or school personnel designated by the school nurse) to administer the medication above to my child, ____.

* Medication must be provided in the original pharmacy or manufacturer labeled container. Only the dose(s) to be given during school hours should be sent to school. Only a 30 day supply of medication can be accepted at any time.

* I understand that I may retrieve the medication from the school at any time and that the medication will be disposed of according to MDPH guidelines, **IF** it is not picked up one week following the termination of the order **OR** one week beyond the close of school.

* I authorize the school nurse to share information regarding the administration of this medication as she deems necessary for the health and safety of my child.

Signature of Parent/Guardian : ____

Date ______________________________

Telephone: ______________________________