St. Mary's Springs Academy

Authorization to Administer Prescription Medication

Student_____ Birth date _____

Grade _____ School Year _____

Parent/Guardian 1: _____ Parent/Guardian 2: _____

Phone Number: _____ Phone Number: _____

Parent/Guardian Medication Consent:

I give permission for my son/daughter to receive the medication listed below. I also give permission for an exchange of information between school district personnel and the health care provider, if necessary, regarding this medication. I agree to notify the school in writing at the withdrawal of this request or when a change in this medication occurs.

I understand that it is my responsibility to:

· Transport the medication to school in the original pharmacy-labeled container (3K through 12th grade)

· Replace the supply of medication when needed

· Pick up medication or direct staff to discard remaining medication upon discontinuation or at the end of the school year

Parent/Guardian Signature _____ Date _____

Health Care Provider's Order for Medication to Be Given at School

Medical Condition:	
Name of Medication: **(generic and trade)**	
Dosage of Medication:	Form: □ Tablet / Capsule □ Liquid: mg / cc / tsp □ Inhaler_____ puffs □ Other _____

Route:	□ Oral □ Eyes □ Ear □ Nose □ Topical □ Other _____
Administration Time:	□ **Daily at: _____** □ **As needed** – Describe frequency & symptoms for which medication should be given: _____ _____ □ May be repeated in _____ _____ minutes/hours. (time)
Possible Side Effects:	
For inhaled asthma medication ONLY:	□ In my professional opinion, this student should be allowed to carry and use this medication by him/herself. □ In my professional opinion, this student **SHOULD NOT** carry this medication by him/herself.

Health Care Provider's Name (Please print) _____

Phone (____)_____

Health Care Provider's Signature _____

Date_____

FOR SCHOOL USE ONLY

· Date received: _____

· Name of person(s) who will administer the Medication:

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