ST. MARY'S SPRINGS ACADEMY

MEDICATION AUTHORIZATION FORM 2025-2026

Student's Name: _____ D.O.B.: _____ Grade: _____

Prescribing Physician: _____

Physician Phone: _____ Physician Fax: _____

Parent Permission: I am requesting that my child receives prescription or over-the-counter medication at the time indicated and as designated by his/her medical provider. I will be responsible for bringing the prescription drugs to school in a labeled container from the pharmacist. I also understand that I am responsible for maintaining a sufficient quantity of the medication or supplies at the school. Failure to do this will result in an interruption of the physician's order or discontinuation of the school's administration of the medication/procedure for my child. I understand that, if my child refuses to take the medication(s), force will not be used by school personnel to make my child comply. School personnel have permission to communicate with the prescribing medical provider regarding use, side effects, response, and contraindications of the medication(s) or the procedure results of frequency. I can rescind my permission at any time.

_____ _____ _____
Parent/Guardian Name/Relationship Address Phone Number

_____ _____ _____
Signature of Parent/Legal Guardian Date Email

PRESCRIPTION Medications: ***To be completed by healthcare provider***

Medication	Strength	Dose Form	Time	Route	Special Instructions	Expiration Date

All medications administered by SMSA staff are only available to students during school hours, must not be expired and in a properly labeled pharmacy box/bottle. Ask your pharmacy for any additional labels or containers needed.

Provider Information/Consent:

Is the student authorized to carry and self-administer prescription medication? ☐ Yes ☐ No
If yes, which medication: _____

Where should this prescription medication be kept? ☐ Backpack ☐ Locker ☐ Other: _____

Print Name of Provider: _____ **Clinic Name:** _____

Signature of Provider: _____ **Date:** _____

NON-PRESCRIPTION Medications:

Medication	Strength	Dose Form	Time	Route	Special Instructions	Expiration Date

Fax # 920-921-5908 Attn: Cassie Morasch