St. Mary's Grade School
MEDICATION ADMINISTRATION AUTHORIZATION

Directions for Parent: Please complete this form if you want **St. Mary's Grade School staff to administer prescription and non-prescription medications to your child**.(1) One of these forms **must** accompany **each** medication to be administered; (2) One of these forms must accompany each **new** medication or **change** in dosage that may occur during the school year; and (3) All types of medications must be in their **original containers**. We ask that **you** deliver your child's medication to designated school personnel (rather than your child.) Thank you for your cooperation!

Student:________________________DOB:_____________Grade:_____Teacher:_______________

INFORMATION ABOUT MEDICATION (Please print):

Name of Medication:__________________________Dose:______________Frequency:______________

Route (Circle One: By Mouth Inhaled/Nasal Apply to skin Apply to Eyes Drop into Ears Other:______________

Reason for Medication:____Continue Until:___________

Instructions for Use:____

Major Side Effects:____

Expiration of Authorization: This authorization shall remain in effect for one school year (including summer school programs after this school year) unless an earlier expiration date is provided here:___________________

(Please note that new "Authorization" forms must be completed prior to the start of each new school year).

Other Information Staff Should Know About Student and this Medication:________________________

____

Health Care Provider to Contact if Concerns/Emergency:_______________________Ph #___________

AUTHORIZATION:

- I give permission to St. Mary's Grade school personnel, and medical personnel contracted by the School to administer this medication. I understand that administration of this medication will not necessarily be done by a nurse.
- I will notify the school immediately if my child's health status changes, or this medication is discontinued.
- I give permission to School personnel and contracted medical staff to contact the physician as needed; and that medication/health information my be shared with staff who need to know.

I have read and understand the "Directions" and "Authorization" sections listed above (circle one): YES NO

I authorize school personnel (and medical personnel contracted by the School) to administer this medication to my child (circle one): YES NO

Parent:____ Date:_________________

Home Phone:_________________Work Phone:_________________Cell Phone:________________