St. Joseph School

REQUEST AUTHORIZATION FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Our school requires physician/dentist/APRN/PA's written order **AND** the parent and/or guardian's authorization for a nurse to administer medications or, in his/her absence, the principal. Medications **MUST** be in pharmacy-prepared containers and labeled with the **NAME** of the student, name of drug, strength, dosage, frequency, name of physician/dentist/APRN/PA's, date of original prescription.

PHYSICIAN/DENSTIS/APRN/PA ORDER

Name of Student _____ Date _____ D.O.B _____

Address _____ Grade _____

Condition for which the drug is needed to be administered during school hours_____

_____

Time of administration _____

Medication shall be administered from _____

Relevant side effects to be observed, if any_____

If there are side effects, plan for management _____

(SIGNATURE) _____

Authorization by Parent/Guardian of the above medication by school personnel:

To School Personnel:

I request that the above medication, ordered by the physician/dentist/APRN/PA for my child _____, be administered by the school nurse or principal. I understand that I mut supply the school with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist and will provide no more than 45 school day supply. I understand that this medication will be destroyed if it is not picked up within one week following the termination of the order one week beyond the close of school.

Parent/Guardian Name: _____Date: _____

Parent/Guardian Signature: _____Relationship to Child: _____

Phone: _____ Date: _____