MARIAN CATHOLIC HIGH SCHOOL

Medication Authorization Form

Physician Order and Parent /Guardian Authorization for Medication Administration
(**Please complete one form, both front and back for each medication**.)

This form is to be complete in its entirety, both front and back.
School Medications and health care services are administered following these guidelines:

- *Physician /Prescriber signed dated Authorization to administer the medication*
- *Parent signed, dated authorization to administer medication.*
- *The medication label contains the student's name, name of medication, directions for use and date.*

Annual renewal of authorization and immediate notification in writing of changes. <u>Only one medication per form</u>

Has the student taken this medication before? Yes No
(If no, the first full dose must be given at home to ensure that the student does not have a negative reaction.)
First dose was given: Date/Time_____

Student Name: Last First Middle

_____ _____ _____

Date of birth School Year Grade

_____ _____ _____

Physician's Authorization (to be completed by health care provider)

_____
Reason for Medication (Diagnosis)

_____ _____ _____
Medication Dosage Route (Oral, Inhalation, etc.)

_____ _____
Time(s) to be administered Intended effect of this medication

_____ _____
Expected side effects, if any Other medications the student is taking

(Continued on next page)

MARIAN CATHOLIC HIGH SCHOOL

Administration Instructions

_____

_____

_____ _____

Physician's Signature Date Signed

_____ _____

Physician's Name (Please Print) Telephone Number

_____ _____

Physician's Address City, State, Zip Code

Parent/Guardian Authorization

Parent(s)/Guardian(s) Authorization I hereby authorize school personnel to administer the prescribed medication to my child during school hours as prescribed by the above physician. I acknowledge that it may be necessary for the administration of medications to my child be performed by any authorized individual and specifically consent to such practices. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the school, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the school, its employees and agents, either jointly or severally, from and against all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

_____ _____

Parent/Guardian Name (Please Print) Telephone Number

_____ _____

Parent/Guardian Signature Parent's/Guardian's Address

_____

Date