INTERNATIONAL SCHOOL OF THE SACRED HEART
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Authorization and Permission for Medication Administration

Student's name _____
FIRST **LAST**

DOB: _____ **Teacher/Homeroom Grade:**_____

Received By: _____ **Date Received**:_____

ISSH School Medication Policy:

- Ø Parent signature and date authorized is required prior to administration of the medication
- Ø All medication must be in the original container and cannot be expired
- Ø Prescription medication must contain student name, name of medicine, directions and expiration date
- Ø Medication changes: must be in writing and prescriptions require a new pharmacy bottle
- Ø This form must be completed annually and all medication must be picked up prior to the last day of school

Medication Name_____**Dosage**_____**Time**_____

Condition for which drug is to be given: _____

Medication Name_____**Dosage**_____**Time**____

Condition for which drug is to be given: _____

Medication Name_____**Dosage**_____**Time**_____

Condition for which drug is to be given: _____

Special Instructions/Allergies:

_____

Other medications student is on: _____

MEDICATION START DATE: _____ **END DATE**:_____

I request the above named student be given the medication at school by qualified staff, according to the prescription or non-prescription instructions and a record maintained. The student has experienced no previous side effects from the medication. Medication information may be shared with school personnel who need to know.

Parent/Guardian Signature: _____

Date: _____ **Email address:**_____

Daytime Telephone Number: _____