

SHORT TERM MEDICATION AUTHORIZATION FORM

Student Name: _____

Please allow my daughter to take the following medication(s) at school:

_____ Dosage: _____ Qty: _____

Administer medicine at _____ time each day or _____ as needed.

This medication is necessary for _____

condition

and should be administered until dosage is completed or by _____.

date

Please contact me at _____ if you have any questions.

Please specify any special instructions for administering and/or storing medicine below:

I agree to indemnify, hold harmless, waive and relinquish any and all claims I may have against Mercy Academy and its officers, agents, employees, representatives or volunteers arising out of, or in connection with the distribution of my daughter's medication as directed by his doctor's or my instructions.

Parent/Guardian Signature

Date

PLEASE NOTE: All prescription medications to be taken during school should be dropped off in the school office accompanied by this completed form. The medicine must be in the original container with the original prescription label. Over the counter medications (including seasonal allergy medication) should also be accompanied by the medication authorization form. It must be in the original container with the student's name written on the package. All medications are kept in the school office. Students may not carry any medication on them with the exception of students with **Long Term Medication Authorization Form** on file with physician's signature for self-administration for asthma or diabetes medication or an Epi Pen.