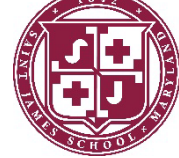


MEDICATION AUTHORIZATION FORM



This form must be completed fully for the school to administer the required medication. A new medication administration form must be completed at the beginning of each school year, **and each time there is a change in dosage or time of administration of a medication.**

PART A: To be completed by medical provider:

Student's Name _____ Date of Birth _____

To keep this student in optimum health and to help maintain maximum school performance, it is necessary that medication be given.

Diagnosis: _____	Dosage _____	Route _____
Medication: _____		
Time(s) given: _____		
Special instructions/side effects? _____		
Diagnosis: _____	Dosage _____	Route _____
Medication: _____		
Time(s) given: _____		
Special instructions/side effects? _____		

(for inhaler or epipen only) Student may _____ may not _____ self-administer

If medication is ordered as needed, please indicate specific circumstances when medication should be given.

OFFICE STAMP:

Printed Name of Medical Provider

Signature of Medical Provider

(_____) _____

Telephone

Date

PART B: To be completed by parent or guardian.

I hereby give permission for my child _____ to receive medication during enrollment at Saint James School. This medication has been prescribed by a licensed medical health care provider. I hereby release Saint James School and its agents and employees from any and all liability that may result from my child taking the medication.

Signature of Parent or Guardian

Date