

St. Francis High School
PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF
MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

All over-the-counter & Prescription medications

A. To be completed by the parent or guardian:

I request that my child _____ DOB _____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy.

B. To be completed by physician:

I request that my patient, as listed below, receive the following medication:

Name of Student _____ DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/ TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____

PLEASE CHECK ONE:

- I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips to my **self directed child**
- I understand that administration of oral, topical or inhalant medications to my **non self-directed child** and injectable medications must remain the responsibility of the school nurse.
- This student is permitted to **self carry** his/her medication or to keep in his/her locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.

Healthcare Provider's Signature: _____

Name: _____

Address: _____ Phone: _____

Signature (Parent or Guardian): _____ Date _____