



**Cristo Rey Orlando High School
Medication Administration Authorization Form**

Student Information:

Student Name:	
Grade:	
Date of Birth:	
Allergies to medications:	• None • Medication name _____ - Reaction _____

Parent/Guardian Authorization (required):

I authorize the school principal or the principal's designee to assist in the administration of the medication(s) listed below during the school day and on school trips, and I certify that the information provided on this form is accurate and up to date.

1. I understand this authorization is valid for the current school year and must be renewed annually or whenever there is a change in medication or dosage.
2. Prescription medications must be in ORIGINAL PHARMACY-LABELED CONTAINERS.
3. OTC medications must be provided in unopened, original manufacturer-labeled package with expiration date intact. labeled with the student's name.
4. Narcotic pain medications **will not** be administered by any school personnel.
5. I understand unused or expired medication not retrieved by year-end will be disposed of according to school policy.
6. The school may contact the prescribing provider if needed.
7. If authorized, a student may self-carry and self-administer medication (e.g., insulin, epinephrine, inhaler) with provider's consent.

Parent/Guardian name (print): _____
Signature: _____ Date: _____

Prescription Medication (one per box):

Medication Name:	
Dosage & Route:	
Administration Time(s):	
Prescribing Providers name and phone number	

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Self-carry / Self-administer if applicable:

The student is authorized to carry and self-administer:

- ☐ Metered dose inhaler
- ☐ Epinephrine auto-injector
- ☐ Insulin/diabetes supplies

Provider authorization (print): _____

Provider signature: _____

Date: _____

Parent/guardian signature: _____

Date: _____

Over-the-counter medication (parent supplied):

Medication name:	
Dose/Route of administration:	
Time(s) to administer:	

Medication name:	
Dose/Route of administration:	
Time(s) to administer:	