BLANCHET CATHOLIC SCHOOL

Authorization for Medication Administration by School Personnel

Principal _____ of Blanchet Catholic School

Student Name:_____DOB:_____ Grade:_____

I am giving school personnel permission to administer medications to my child per the following:

Parent or Physician please complete (Remember to check appropriate boxes below):

Medication: _____

Dose (how much): _____

Tablets requiring cutting should be cut by the parent before being sent to school. Liquid medication requires dosage spoons, available from your pharmacist, to be supplied by parent.

Route: (circle one)
By: Mouth Ear Eye Nose Skin Inhalation

Time to be given at school: _____

Duration: Start date_____ End date_____

Reason for Medication: _____

Special Instructions: _____

_____

☐ Non prescription

☐ Prescription Rx number_____

ALL MEDICATION MUST BE IN ITS NEWEST ORIGINAL CONTAINER WITH ACCURATE LABEL.

I understand I am responsible to provide the listed medication to the school and maintain the supply as needed. I also understand I am responsible to notify the school **in writing** of any changes. Parents are required to pick up all unused medication by the last day of school. All medication left at the school will be discarded.

Parent/Guardian Signature:_____Date:_____

(This authorization applies only to the medication listed above and for the duration of treatment or school year). This also authorizes an exchange of information, as necessary, between the school nurse, appropriate school personnel, and/or my child's health provider.

PHYSICIAN'S DIRECTION

(required in writing or on pharmacy label for all prescription medications).

I have prescribed the above medication for the student listed above. Instructions in the box are accurate.
Special instructions including adverse reactions and action required:_____

_____

_____ _____

Physician's Name (please print/stamp) Address

_____ _____ _____

Physician's Signature Phone Number Date