HOLY ROSARY SCHOOL PARENT FORM

AUTHORIZATION FOR ADMINISTERING MEDICATION AT SCHOOL

One Form Required Per Medication

Date: _____

Student Name: _____

Date of Birth: _____ **Grade:** _____

Homeroom/Teacher: _____

Name of Medication: _____

Strength: _____

Dosage: _____

Route of Administration:
☐ Oral ☐ Topical ☐ Inhaled ☐ Other: _____

Purpose/Reason for Medication: _____

Time(s) to be Administered: _____

Allergies:_____

Possible Side Effects: _____

Special Instructions: _____

Termination Date for Administration: _____

I, _____, parent/guardian of

_____, hereby request and authorize

Holy Rosary School and its authorized personnel to administer the medication listed above to my child in accordance with the instructions provided by the child's physician and this authorization.

I understand that **prescription medications must be accompanied by a current prescription, and over-the-counter medications must be accompanied by a current physician's authorization** before the school may administer the medication.

Parent/Guardian Signature: _____**Date:** _____

SCHOOL USE ONLY

Date Received: _____

Received By: _____

☐ Parent/Guardian Authorization Form received

☐ Current Physician's Authorization/Order received

☐ Medication received in required original container

☐ Student name matches authorization documents

☐ Medication name matches authorization documents

☐ Dosage and administration instructions match authorization documents

☐ Termination date verified

☐ Medication Receipt & Inventory Form completed

☐ Medication placed in student's designated Medicine Box

☐ Student photo verified/updated

Reviewed/Approved By: _____

Signature: _____ Date: _____