Medication Authorization for Administration

STUDENT NAME **BIRTHDATE** **GRADE**

This portion is to be completed by the physician/dentist:

MEDICATION	DOSAGE	METHOD OF ADMINISTRATION	TIME OF DAY FOR ADMINISTRATION

Specify the length of time between **RX** doses: ______________________

Inhalers: ☐ Must be carried on his/her person ☐ Optional to carry on his/her person

Possible side effects of **RX:**______________________

Emergency procedure in case of serious side effects:______________________

I request and authorize that the above-named student be administered the above-named identified oral medication in accordance with the instructions indicated above from _________________to __________________ (not to exceed the current school year) as there exists a valid health reason, which makes the administration advisable during school hours.

NAME OF PHYSICIAN / DENTIST (PRINTED) **SIGNATURE OF PHYSICIAN / DENTIST**

TELEPHONE NUMBER **DATE OF SIGNATURE**

PLEASE NOTE: If samples of medication are provided, the samples must be labeled with the name of the student, dosage, and time to be given.

This portion is to be completed by the parent/guardian:

I request/authorize Kennedy Catholic High School to administer medication to the student identified above in accordance with the physician's instructions for the period from________________to __________________ (not to exceed the current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner.

☐ Permission for student to carry on his/her person

NAME OF PARENT/GUARDIAN (PRINTED) **SIGNATURE OF PARENT/GUARDIAN**

TELEPHONE HOME **TELEPHONE WORK / CELL** **DATE OF SIGNATURE**