2017-2018 School Year

Department of Catholic Schools Form 5910.1

Diocese of Wheeling-Charleston

MEDICATION ADMINISTRATION AUTHORIZATION FORM

Medications should be administered to students by their parents/guardians at home whenever possible. In the event this is not possible, consent must be given and the following form completed.

For all Prescription/Over the Counter Medications, written authorization from parent/guardian **and** licensed health care provider are required.

Parent/Guardian Authorization

1. I request that the above medication be given to my child during school hours as ordered by his/her licensed health care provider.
2. I will immediately notify the school of any change in the medication or licensed health care provider order, dosage change, frequency, or duration of administration.
3. I will provide the prescription medication in the original container from the pharmacy with label affixed: student's name, name of the medication, reason(s) for the medication, dosage, time, frequency, method of administration and date that the prescription and/or medication expires.
4. I will provide over the counter medication in the original manufacturer's bottle and include: student's name affixed to the bottle, name of the medication, reason(s) for the medication, dosage, time, frequency, method of administration and date that the medication expires.
5. I will pick up any unused portion of medication within 30 days of discontinued date or by the last day of school.
6. I give permission for designated school personnel to administer the medication.
7. I give permission for designated school personnel to administer the medication on a field trip or school activity as ordered.
8. I release all school personnel harmless for any and all liability for damages or injury resulting directly or indirectly from the presence of medication in the school or its use by my child.

____**Date:**___________ **Phone:**_______________

(Parent/Guardian Signature)

Licensed Health Care Provider Completes This Section (*Please Print):*

Student's Name: ____

School: ____

Birthdate____________________Age:__________Grade:__________Allergies:____

Name of Medication: ____Dosage to be given: ______________________________

Time/frequency to be administered: ____

Method of Administration (i.e. oral, inhale) ____

Other recommendations/Side Effects/Special Considerations: ____

Diagnosis/Medical reason for medicine: ____

X____Date: ______________ Phone: ____________________

(Licensed Health Care Provider Signature)