St. Patrick Catholic School

Authorization for Medication Administration

Parent/guardian shall deliver medication and this completed form to the school office.

I, the undersigned, as parent/guardian of _____Grade_____
Student's Name
attending St. Patrick Catholic School request that the following medicine(s) be made available to my child at the time prescribed by the physician.

I understand that only personnel authorized by the school will assist my child in taking the medicine(s) as directed by my child's physician.

I will provide the medicine(s) in the prescription container(s) which is labeled with the name of my child, the prescribing physician name, and the amount of medicine prescribed.

If any conditions in the physician's statement change, a new form must be signed by the parent/guardian and the physician.

Prescription and nonprescription medications are not permitted to be taken at school without a written statement from the physician and a written statement from the parent indicating desire that the school assist the student as set forth in the physician's statement below.

I recognize the fact that this is a service or accommodation which the school is not legally required to perform. I agree to save and hold the school, it's officers, employees or agents, harmless from all liability, suits or claims, or whatever nature or kind, which might arise as a result of administering the medication in accord with this request.

_____ _____
Parent/Guardian Signature **Date**

_____ _____
Work phone **Home phone**

This form is valid only for school year 20___to 20___.

This portion to be completed by a physician licensed in the State of California

Name of Medication	Method of Administration	Dosage	Time
#1_____	_____	_____	_____
#2_____	_____	_____	_____

1. Discontinuation of medicine #1 on _____ and Medication #2 on _____.
Date **Date**
2. Diagnosis _____ Reason for giving medication.
3. Type of assistance for administering medication.
4. Precautions for administration or storage of medication
5. Do you wish to have school personnel contact you at intervals to discuss this medication?

Please indicate: Person/s_____ Intervals_____
Teacher/Resource **Daily, Weekly**

_____ _____ _____
Printed Name of Physician **Medical Lic. #** **Phone Number**

_____ _____
Signature of Physician **Date**