

St. Peter School
Authorization for Administration of Medication at School

Student Name _____ Grade _____ Birth Date _____

Name of Medication Dosage Method of Admin Time of Day

If given prn (as needed) specify what it's being taken for and length of time between doses.

Permission to carry inhaler/epi-pen _____ Yes * _____ No
All medications (except epi-pen, inhalers & glucagons) must be kept in the school health office.

Possible side effects of medication _____

Safe for unlicensed staff to administer student medication _____ Yes _____ No

Emergency procedure in case of serious side effects _____

I request and authorize that the above named student be administered/provided the above identified 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 administration of the medication advisable during school hours.

Date

Parent/Physician/Dentist/Provider

Phone #

Please Note: Medications must be sent to the school health office in their original container. Separate authorization forms should accompany each medication. If samples of medication are to be given, they must be labeled with the name of the student, dosage, route, and time to be given.

***If you marked yes for permission to carry inhaler/epi-pen, you will be required to fill out a document that St Peter's is required to have on file.**