Diocese of Rockford

MEDICATION AUTHORIZATION

If at any time during the school year it become necessary for a student to take medication (either prescribed or over the counter medicine) during the school day, this parent/guardian request form to administer the medication to the student must be completed and on file in the principal's office. The pharmacy label can serve as the written consent of the physician.

I request that the medication described below be administered to my child at the times specified during the school day. I will provide the principal/secretary with this medication in a container provided by the pharmacist. I understand that this medication will be dispensed to my child only by the principal or office personnel; and that the medication will be kept secure in a locked cabinet or refrigerator. I understand that this consent is valid for one year and must be renewed annually or whenever there is a change in medication.

Student's Name _____ Grade Level/Classroom # _____

Name of Medication _____ _____Prescription ___Over-the-Counter

Days Medication is to be Given _____ Time to Administer _____

Dosage _____ Refrigeration Required? ___Yes ____No

Purpose of Medication: _____

Physician's Name _____ Physician's Phone _____

Physician's Signature _____ **Date** _____

Pharmacy _____ Prescription Number _____

Pharmacy _____ Prescription Number _____

This medication is to be given to my child only until _____

Parent/Guardian Signature _____ **Phone** _____ **Date** _____