Authorization - Permission to Dispense Prescription Medication

Student's Full Name: _____

Grade: _____ **Date of Birth**: _____/_____/_____

St. Catherine's School will assist parents whose physician has prescribed prescription medications. All drug containers must be marked with the name of the student and dosage instructions and must be taken in the main office. The school will assume no responsibility for administering over-the-counter, non-prescription medicines or drugs. These medicines should be taken before school, after school, or with a parent present in the office (form will be signed).

The following medication has been authorized and approved:

Name of the Medication: _____

Form: _____ Dose: _____

☐ Long-term ☐ Short-term: Approved dates_____

Medicine is administered daily. ☐ Yes ☐ No

If YES, what time? _____

Medicine is administered as needed. ☐ Yes ☐ No

If YES, what are the indications? _____

Pharmacy: _____ Phone #: (_____) _____-_____

Physician's Name: _____ Phone #: (_____) _____-_____

Additional Comments: _____

_____

Physician's Signature: _____ **Date**: _____

As a parent/guardian of the above-named student, I request the school to dispense medicine to my child as indicated on this form. Furthermore, the school has my permission to contact the physician in regard to the medication prescribed.

Parent/Guardian Signature: _____ **Date**: _____