St. Thomas the Apostle School

Parent and Physician's Authorization for Administration of Medication in School and School Activities

To be completed by the parent/guardian

I request that my child ___________________________________, Date of Birth: ________________________ receive medication as prescribed below by our physician. The medication is to be furnished by me and properly labeled in the original container from the pharmacy*.

Please check one

- ☐ I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips to my **self directed child.**
- ☐ I understand that administration of oral, topical or inhalant medications to my **non self directed child** and injectable medications must remain the responsibility of a school nurse or licensed practical nurse under the direction of a physician, or parent.

________________________________ _____/_____/__________ ______________________________

Parent Signature Date Parent Name, Please Print

________________________________ ______________________________ ______________________________

Home Phone Work Phone Cell Phone

To Be completed by the Physician

I request that my patient, as listed below, receive the following medication:

____ ______________________________

Student Name Date of Birth

____ ______________________________

Diagnosis Duration of Treatment

Medication	Dosage	Frequency/ Time to be Taken	Route of Administration

____

Possible Side Effects and Adverse Reactions (if any)

____

Physician Printed Name or Stamp

____ ______________________________

Physician Signature Date

** Medication must be in original pharmacy labeled container with specific orders and name of medication*
** Medication and refills must be brought to school by parent, guardian or responsible adult.*

Plan reviewed with parent(s)/guardian(s):

____ ______________________________

Parent Signature Date