St. Thomas School

# 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 r equest that my child _____, Date of Birth: _____
rec eive medication as prescribed below by our physician. The medication is to be furnished by me and properly lab eled 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.

__ _____ _____/_____/_____ _____

Par ent Signa ture 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 Date

Signature *

*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