

***Authorization for Administration of Medication at School***

Student Name \_\_\_\_\_ Birth Date: \_\_\_\_\_

**Blessed Sacrament School** Grade: \_\_\_\_\_

***THIS PORTION TO BE COMPLETED BY PHYSICIAN/DENTIST/PROVIDER***

<u>Name of Medication</u>	<u>Dosage</u>	<u>Route</u>	<u>Time of Day</u>
_____	_____	_____	_____

Please give length of time between doses: \_\_\_\_\_

Inhalers: \_\_\_\_\_

(Indicate if student must carry on his/her person)

Possible side effects of medication:  
\_\_\_\_\_  
\_\_\_\_\_

*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 of Signature Physician/Dentist/Provider Signature

\_\_\_\_\_  
Telephone Number Name: \_\_\_\_\_  
(Print or Type)

*Please note: 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.*

.....  
**THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN**

*I request/authorize the school to give medication to my student in accordance with the health care provider's instructions written above. I understand that unlicensed staff may be assigned to provide medication to my student, and I accept ultimate responsibility for monitoring the effects of this medication.*

Permission to carry inhaler \_\_\_\_ Yes \_\_\_\_ No  
Permission to self-administer medication \_\_\_\_ Yes \_\_\_\_ No

\_\_\_\_\_  
Date Parent/Guardian Signature Phone # \_\_\_\_\_  
Home Work

***Competency Statement***

I, \_\_\_\_\_ have determined  
(Parent/Guardian Name)  
Blessed Sacrament School Staff competent to give or apply  
medication to my child(ren). I understand that Child Care Center  
and Preschool Directors have the responsibility to assess the ability  
of staff to give or apply medication safely and may give  
medication to my child(ren).

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent/guardian