2023-2024
St. Francis Solano Catholic School
SCHOOL MEDICATION AUTHORIZATION

Student's Name: _____ Grade:_____ Height (inches)_____ Weight (lbs)_____

List any known drug allergies/reactions

_____

PRESCRIBER AUTHORIZATION

Name of Medication: _____

Reason for Taking: _____

Dosage Route Frequency/Time(s) to Be Given _____
Date to Begin Medication: _____ Medication to end on: _____

Special Instructions:
Does medication require refrigeration? Yes □ No □
Is the medication a controlled substance? Yes □ No □
Is self-medication permitted and recommended for this student? Yes □ No □
I hereby affirm that this student has been instructed in the proper self-administration of the prescribed medication(s) Yes □ No □
This is daily medication, which will be administered at school (with directions "on an empty or full stomach," already provided by parent) Yes □ No □

Potential Side Effects/Contraindications/Adverse Reactions: _____

Signature of Physician Prescribing Medication _____

Date_____ Phone _____

PARENT AUTHORIZATION

Medication must be registered in the school office. It must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug's expiration when appropriate.

□ I authorize the school personnel to assist my child in taking the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.

□ I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

The school assumes no responsibility of liability for the medication given or reactions which might result.

_____ _____
Signature of Parent or Guardian **Date**