OVER THE COUNTER/PRESCRIPTION MEDICATION AUTHORIZATION, *2023-2024*

NAME: _____ **GRADE:** _____ **DOB:** _____/_____/_____

Last First Middle

I am requesting that an authorized representative of Holy Name Catholic School administer the following medication or treatment:

☐ **PRESCRIPTION (complete label info below)**

☐ **OVER THE COUNTER**

The following information is contained on the prescription label and must be current.

_____

Pharmacy Name Phone Number Prescription Number

_____

Verified Medication, Dose, and Frequency

_____

Physician's Name

Medication: _____

Directions for Administration/Side Effects:

_____

_____

Medication Administration:

Beginning Date: ____/_____/_____ **End Date:** ____/_____/_____

A. I give permission for my child to deliver medication to the health clinic at the beginning of the school year or when necessary and permission to retrieve medication from school at the end of the school year. Medications left at school following the close of the school year will be destroyed.

B. I will notify school immediately if there is any change in the use of the medication(s)/treatment.

_____

Parent/Guardian Signature **Date**

_____

Parent/Guardian Printed Name

_____

Phone #

PERMISSION IS VALID ONLY FOR THE CURRENT SCHOOL YEAR AND ONLY FOR THE STUDENT LISTED ON THE FORM. STUDENTS ARE NOT PERMITTED TO SHARE THEIR MEDICATIONS WITH OTHER STUDENTS. VIOLATIONS WILL RESULT IN DISCIPLINARY ACTION.