Academy of Our Lady Of Grace

Medication Authorization During School Hours

DOCTOR FILLS IN REQUIRED SECTIONS. Parents sign and return completed form to the school nurse. This form is required for over-the-counter or prescription medication administered in school. Please do not make any changes to this form

STUDENT: _____ GRADE: _____

DATE OF BIRTH: _____ HOME PHONE:_____

Medication taken at home YES: _____ NO: _____

Name of Medication(s) taken at home: _____

_____

The following **prescription medication** may be administered to my patient:

MEDICATION: _____DOSAGE: _____

TIME TO BE GIVEN: _____ GIVEN FOR:_____

SIGNIFICANT SIDE EFFECTS: _____

MEDICATION:_____DOSAGE: _____

TIME TO BE GIVEN: _____ GIVEN FOR:_____

SIGNIFICANT SIDE EFFECTS:_____

The following **over-the-counter medication(s)** may be administered to my patient:

Cough Drop: _____ How frequently: _____ As needed for: _____

Tylenol: 325 mg _____ How many: _____ Frequency: _____
OR 160 mg _____ How many: _____ Frequency: _____ As needed for:

Motrin/Advil: 200 mg _____ How many: _____ Frequency: _____
OR 100 mg _____ How many: _____ Frequency: _____ As needed for:

Medication:_____ Dosage: _____ Frequency: _____ As needed for:_____

Medication:_____ Dosage: _____ Frequency: _____ As needed for:_____

Medication:_____ Dosage: _____ Frequency: _____ As needed for:_____

Doctor Name (print): _____ Date: _____

Doctor Signature: _____ **Doctor Stamp**:

I request for my child, _____, to receive medication as listed above. I have been informed that the school, its agents, and employees shall incur no liability whatsoever as a result of any untoward reaction arising from the administration of medication to my child.

Parent Name (print): _____ Date_____

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Parent Signature: _____