

# Medication Authorization Form



Diocese of Joliet

## MEDICATION AUTHORIZATION

If at any time during the school year it becomes necessary for a student to take medication (either prescribed or over the counter medicine) during the school day, this parent/guardian request form to administer the medication to the student must be completed and on file in the principal's office. The pharmacy label can serve as the written consent of the doctor.

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I request that the medication described below be administered to my child at the times specified during the school day. I will provide the principal/school nurse with this medication in a container provided by the pharmacist. I understand that this medication will be administered to my child only by a school nurse, the principal, or office personnel, and that the medication will be kept secure in a locked cabinet or refrigerator. I understand that this consent is valid for one year and must be renewed annually or whenever there is a change in medication.

\_\_\_\_\_  
Student's Name

\_\_\_\_\_  
Grade Level/Classroom #

\_\_\_\_\_  
Name of Medication

\_\_\_\_\_  
Prescription

\_\_\_\_\_  
Over-the-Counter

\_\_\_\_\_  
Days Medication to be Given

Time to Administer: \_\_\_\_\_

\_\_\_\_\_  
Dosage

Refrigeration Required? \_\_\_\_\_

\_\_\_\_\_  
Purpose of Medication:

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Physician's Phone

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Pharmacy

\_\_\_\_\_  
Prescription Number

\_\_\_\_\_  
This medication is to be given to my child only until:

\_\_\_\_\_  
Parental/Guardian Signature

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date