St. Peter Catholic School
Authorization for Administration of Medication at School

Student Name _____ Grade_____ Birth Date_____

Name of Medication	Dosage	Method of Admin	Time of Day
_____	_____	_____	_____

If given PRN (as needed), specify what the med is being taken for and length of time between doses.

_____

Permission to carry inhaler/Epi-pen: _____ Yes* _____ No

All medications (except Epi-pens, inhalers & glucagons) must be kept in the school health office.

Possible side effects of medication: _____

Safe for unlicensed staff to administer student medication: _____ Yes _____ No
I would like my child to receive this medication on early dismissal days: ____ Yes _____ No
I would like my child to receive this medication on field trips: _____ Yes _____ No

Emergency procedure in case of serious side effects: _____

_____

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 _____
(please list dates - not to exceed this school year)

as there exists a valid health reason which makes administration of the medication advisable during school hours.

_____	_____	_____
Date	Parent/Physician/Dentist/Provider	Phone #

Please Note: Medications must be sent to the school health office in their original container. Separate authorization forms should accompany each medication. 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.

***If you marked yes for permission to carry inhaler/Epi-pen, you will be required to fill out a separate document that St. Peter Catholic School is required to have on file.**