PRESCRIPTION MEDICATION AUTHORIZATION

St. Patrick School

Date Received:____________________

STUDENT NAME:____ GRADE:___________

DATE OF BIRTH:______/______/______ TEACHER'S NAME:____

To be completed by parent/guardian (physician's signature is required):

Prescription medication #1:____

Dosage:________________ Time to be given:_________________ Route: ☐mouth ☐inhaler ☐topical ☐drops ☐injection

Desired action of medication:____

Side effects of medication:____

Special instructions:____

Specify medication type: ☐ Daily ☐ Emergency ☐ As Needed

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Prescription medication #2:____

Dosage:________________ Time to be given:_________________ Route: ☐mouth ☐inhaler ☐topical ☐drops ☐injection

Desired action of medication:____

Side effects of medication:____

Special instructions:____

Specify medication type: ☐ Daily ☐ Emergency ☐ As Needed

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Physician's Signature:____ Date:_____/______/_____

Physician's Name (Print)____

Address____

Phone______________________________ Fax______________________________

This student is both capable and responsible for self-administering this medication:
☐ No ☐ Yes-supervised ☐ Yes-unsupervised

If "Yes-unsupervised" complete the self-administration authorization form.

To be completed by parent/guardian:

I hereby request that my child ____ receive the above prescription medication at school per the physician's order and the St. Patrick School Medication Policy.

Signature:____ Date:____________________
Parent/Guardian Signature

Relationship to student:____