

Authorization for Administration of Medication at School 2018-2019

## This form must accompany any medication & must be signed by a doctor

Student name \_\_\_\_\_

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Date of Birth \_\_\_\_\_

Forest Ridge School of the Sacred Heart **2018-2019** school year\*. Grade \_\_\_\_\_

<u>PLEASE NOTE</u>: ALL medication to be administered or taken at school must be in <u>original</u> <u>container(s)</u> labeled with the student's name, dosage, and time to be administered, INCLUDING OVER-THE-COUNTER MEDICINES such as cough drops, Advil, Tums, etc. Medications must accompany this completed form and given to Mrs. Jacob/Summer Program Director. PLEASE USE SMALL PACKAGING. School does not provide OTC medication of any kind.

## **PHYSICIAN OR DENTIST MUST COMPLETE THE FOLLOWING PORTION:**

Name of medication(s)	Dosage(s)	Time(s) of day to be taken	Reason for medication
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If administered prn, specify the length of time between doses			
Inhaler(s) Student <u>must</u> carry on her person yes no			
(Circle one) (Circle one - yes no			
Possible side effects of medication(s)			
Emergency procedure in case of serious side effect			
I request and authorize that the above-named student be administered the above-identified medication in accordance with the instructions indicated from dates: to, as there exists a valid health reason which makes administration of the medication(s) advisable during school hours.			
Physician / Dentist sig	jnature		Date
Physician / Dentist name	printed		Office phone number

## THIS PORTION MUST BE COMPLETED BY THE PARENT / GUARDIAN:

I authorize the school to administer medication to the above-identified student in accordance with the doctor's instructions for the period of time stated above.

Permission to carry inhaler: Circle one - yes no

Parent / Guardian signature

Date

Home telephone

Parent alternate telephone

\*This form is valid only through Sept. 20, 2019. To be used for the 2018-2019 school year and summer 2019.