

ST. JOHN THE EVANGELIST SCHOOL
8912 OLD BRANCH AVENUE
CLINTON, MD 20735

MEDICATION AUTHORIZATION FORM
PRESCRIPTION and NON-PRESCRIPTION
(ONE MEDICATION PER FORM)

SCHOOL YEAR: 2008-2009

FOR COMPLETION BY PARENT/GUARDIAN:

STUDENT'S NAME _____ **GRADE** _____

- ❖ I understand that I must supply the school with the medication and any equipment or supplies needed to administer the medication.
- ❖ I understand that I must administer the first dose of any new medication.
- ❖ I understand that ALL medicine must be in the ORIGINAL LABELED CONTAINER. Prescription medications must be labeled by a pharmacist with the student's name, name of the medication, date filled, directions for administering, and the name of the prescribing physician.
- ❖ I authorize the medication described below to be administered to my child as directed on this form.
- ❖ I understand the prescribing physician will be contacted if any questions arise related to the medication. If necessary, I authorize the release of any information necessary for the care of my child.
- ❖ I understand that 911 will be called in the event of an emergency.

FOR COMPLETION BY AUTHORIZED PHYSICIAN

- ❖ Name of medication: _____
- ❖ Reason for medication: _____
- ❖ Route of administration: _____
- ❖ Dosage of medication: _____
- ❖ Time medication should be given: _____
- ❖ Date to begin medication _____ Date to end medication _____
- ❖ Possible side effects: _____
- ❖ Additional information _____
- ❖ _____

PHYSICIAN SIGNATURE _____ **DATE** _____

PHYSICIAN PRINTED NAME _____ **PHONE #** _____