ICRS | IMMACULATE CONCEPTION REGIONAL SCHOOL

AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____ Grade: _____

SAVE THIS FORM IF NEEDED IN THE FUTURE.....
FOR PRESCRIPTIONS: Signatures needed from Doctor & Parent!
FOR OVER THE COUNTER DRUGS: Need to be signed by parent only!

Name of Medication _____ Dosage _____ Time of Day _____

Methods of administration _____

If given PRN specify the length of time between doses _____

Inhalers: _____
Indicate if student must carry on his/her person: yes____ no____

Possible side effects of medication _____

Emergency procedure in case of serious side effects _____

_____

I request and authorize that the above-named student be administered the above- identified oral medication in accordance with the instructions indicated above from _____ to _____ (not to exceed current school year) as there exists a valid health reason, which makes administration of the medication advisable during school hours.

_____
Date/Physician Signature Date/Dentist Signature

_____
Printed Physician Name Printed Dentist Name

Telephone Number: _____

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request/authorize the school to administer medication to the above identified student in accordance with the Doctors' instructions for the period from _____ to _____ (not to exceed current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner.

Permission to carry inhaler: Yes_____ No_____

_____
Date/Parent/Guardian Signature Printed Parent/Guardian Name

Telephone Number: _____

SAVE THIS FORM IF NEEDED IN THE FUTURE.....

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