2018-2019 PRESCRIBED MEDICATION
AND TREATMENT AUTHORIZATION

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO RECEIVE PRESCRIBED MEDICATIONS/TREATMENT IN SCHOOL.
ALL SPACES MUST BE COMPLETED. PLEASE PRINT.

Name _____
Last First Middle

Gender ___ **Grade** ___ **Homeroom Teacher** _____ **Birth Date** ____/_____/_____

The following information is contained on the prescription label and must be current.

_____
Pharmacy Name Phone Number Prescription Number

_____
Verified Medication, Dose, and Frequency

_____
Physician's Name

I am requesting that an authorized representative of Holy Name Catholic School administer the following prescribed medications(s) or treatment:

Prescribed Medication/Treatment:

_____

Directions For Administration/Side Effects:

_____

_____

Medication Administration

Beginning ____/_____/_____ End ____/_____/_____

_____
Signature of Physician

_____
Printed Name of Physician

A. I give permission for my child to deliver medication to the health clinic at the beginning of the school year or when necessary and permission to retrieve medication from school at the end of the school year. Medications left at school following the close of school year will be destroyed.

B. I will notify school immediately if there is any change in the use of the medication(s)/treatment.

_____
Parent/Guardian Signature Date

_____
Parent/Guardian Printed Name

_____
Home phone Cell Phone Work Phone

PERMISSION IS VALID ONLY FOR THE CURRENT SCHOOL YEAR AND ONLY FOR THE STUDENT LISTED ON THE FORM. STUDENTS ARE NOT PRERMITTED TO SHARE THEIR MEDICATIONS WITH OTHER STUDENTS. VIOLATIONS WILL RESULT IN DISCIPLINARY ACTION.