ST. JACOBI SCHOOL

PARENT AND PHYSICIAN AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

School: _____ School Year: _____ Grade: _____

Name of Student: _____ Date of Birth: _____

Address: _____ Home phone: _____

Parent(s) Name: _____ Work Phone: _____

Name of Medication: _____

Dosage: _____ Route: _____ Hour(s) Administered: _____

Reason for Medication: _____

_____

Physician Prescribing Medication: _____

Address: _____ Phone: _____

☐ If approved by their physician, I allow my child to carry their Epi-Pen and/or Inhaler,

I agree to notify the school in writing at the termination of this request or when any changes in the above order are necessary.

_____ _____

(Signature of Parent/Legal Guardian) (Date)

Note: Before medication prescribed by a physician can be administered by school personnel, a signed statement from the physician which includes the conditions and circumstances for administering the medication, the prescribed dosage, and the frequency of administration must be on file. The 'Physician Order for Medication' below may be used for this purpose.

Physician Order for Medication

Name of Student: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication and Dosage: _____

Medication Frequency/Time: _____

Conditions under Which Medication Should Be Given: _____

_____

Contraindications / Side Effects: _____

If the medication is an inhaler or Epi pen:

☐ Check box if student may carry the inhaler with him/her.

☐ Check box if student may carry Epi-Pen with him/her

Physician's Signature: _____ Date: _____

Physician's Address: _____ Phone: _____

LR/SII-Med sheet updated 06/06