



# Archdiocese of Seattle, Office for Catholic Schools

## AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

### THIS PORTION TO BE COMPLETED BY THE PHYSICIAN/DENTIST

<i>Name of Medication</i>	<i>Dosage</i>	<i>Methods of Administration</i>	<i>Time of day to be taken</i>
_____	_____	_____	_____

If given prn specify the length of time between doses \_\_\_\_\_

Inhalers: \_\_\_\_\_

*Indicate if student must carry on his/her person*

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 of Signature*

\_\_\_\_\_  
*Physician/Dentist Signature*

Phone: \_\_\_\_\_

Name: \_\_\_\_\_

*Print or Type*

*Please Note: If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.*

### 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 doctor's 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

\_\_\_\_\_  
*Date of Signature*

\_\_\_\_\_  
*Parent/guardian Signature*

Phone: \_\_\_\_\_

*Home*

*Work*

E-mail: \_\_\_\_\_