BUILDING FUTURES WITH FAITH

SAINT JAMES SCHOOL
ARLINGTON HEIGHTS

PHYSICIAN AND PARENT

SCHOOL MEDICATION AUTHORIZATION FORM

To be completed by parent or guardian:

I,____(parent/guardian) understand that the prescribed medication described below is to be administered by the school nurse. However, the school nurse may identify circumstances (fieldtrips, nurses' absence, etc.) where certified staff will directly assist my child in taking his/her medication when needed. I also will take the responsibility for ensuring that the medication arrives safely at school in a pharmacy-labeled container

____ ____________________

(Parent/Guardian Signature) (Date)

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To be completed by physician:

Student's Name:____DOB______________

Address:____Phone:_________________

Medication:____

Dosage:____Time:__________________

Purpose of Medication & expected outcome:______________________________________

____

Possible side effects:____

Special instructions for administration:____

Date:_____________ Physician Name(print):___________________________________

Physician Signature:____

Phone:___________________________________