ICRS | IMMACULATE CONCEPTION REGIONAL SCHOOL

AUTHORIZATION FOR ADMINISTRATION OF ORAL MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____
School: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY THE PHYSICIAN/DENTIST

Name of Medication _____
Dosage _____
Time of Day _____
Methods of administration to be taken _____

_____
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 _____

_____
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.

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 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/Parent/Guardian Signature Printed Parent/Guardian Name

Telephone Number: _____