ST. MICHAEL SCHOOL

AUTHORIZATION FOR NON-PRESCRIPTION MEDICATION

The use of medication during school hours is discouraged.
Use this form if it is essential a student receives medication during the school day.

Student's Name: _____ D.O.B.: ___ / ___ / _____

School Year: 20___ - 20___ Grade: _____ Homeroom: _____

Parent's Name: _____

Primary Phone: (_____) _____ - _____ Secondary Phone: (_____) _____ - _____

Name of Medication[1]: _____

Concentration of Medication: _____ (mg/tablet or mg/mil)

Reason for Medication to be administered at school. Please be specific:

_____

_____

Amount of Medication to be given (in milligrams or units): _____

Date to Start Medication: ___ / ___ / _____
Date to Stop Medication: ___ / ___ / _____

Physician: _____ Physician's Phone: (_____) _____ - _____

To be completed by parent/guardian:
I understand that all medication will be provided by me in the original container, unopened, with my child's name clearly labeled. I understand that all medication must be delivered to the school main office or school nurse by a parent/guardian. I will notify the school nurse in writing should my child develop any condition or reason for the medication to be discontinued. I am responsible for picking up any unused medication at the end of the school year. Permission is granted to the administration and/or school nurse to share this information with individuals who have responsibility for my child (for example, teachers).

Parent Signature: _____ Date: ___ / ___ / _____

[1] A separate form is required for each medication to be given.