ST. MICHAEL PARISH SCHOOL

Authorization for Non-Prescription Medication at School

Please Print

Grade Level: ______ Homeroom: ________________________ School Year: ________________

Student's Name: ____ Birth Date: _____________________

Parent's Name: ______________________________________ Daytime Phone: ____________________

*Name of Medication: ____

Concentration of medication (mg/tablet or mg/ml): ____

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: _______________________

Student's Physician: ________________________________ Physician 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 ____________________

*A separate form is required for each medication to be given.