Medication Administration Permission

Holy Family Catholic School

Phone (810)694-9072 FAX # (810)694-9405

School Year_____

Student's Name: _____

Date of Birth: _____ Age_____ Grade: _____

ALLERGIES: _____

Name of Medication:

_____

Reason for Medication:

_____

Form of Medication: (circle)

Tablet Liquid Inhaler Injection Nebulizer

Dose (How many Mg or Ml to be given)

_____

Time to be Given at School or as needed

_____

Effective for 2024/2025 School Year (Circle) YES or NO

or Start and Stop Date:

_____

Special Instructions: (refrigerate or with food, etc.)

Name of Medication:

_____

Reason for Medication:

_____

Form of Medication: (circle)

Tablet Liquid Inhaler Injection Nebulizer

Dose (How many Mg or Ml to be given)

_____

Time to be Given at School or as needed

_____

Effective for 2024/2025 School Year (Circle) YES or NO

or Start and Stop Date:

_____

Special Instructions: (refrigerate or with food, etc.)

Physician's Signature: _____ Date: _____

Physician's Name: _____

Physician's Address: _____ _____

Physician's Phone Number: _____

To be completed by the Parent/Guardian:

I give permission for the above medications to be given by designated Holy Family School Staff.

Signature: _____Date: _____

Relationship: _____ Phone: _____

*Includes prescription & over-the-counter medications, i.e. Tylenol, Benadryl, Claritin, ibuprofen, Neosporin, etc.

A Valid and current dated form must be submitted each school year.