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(s) for Medication:

_____

Form of Medication/treatment: (Circle one) Tablet Liquid Inhaler Other: _____

Schedule and dosage to be given at school: (ex: Motrin 200mg, 2 tablets, every 6 hrs or as needed)

_____

Start Date: _____

Stop Date: _____ or: End of School Year _____

Restrictions and/or important side effects _____

**If the student is capable of self-administration or must carry this medication a *Permission to carry medication* form must also be filled out.

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.