Medical Authorization

The following section is to be completed by the **PARENT/GUARDIAN** for the administration of medication. Medications must be in original containers.

Child's Name:______________________________ ________ ____________
Last First Sex Date of Birth

____(______) ____________
Physician's Name Address Telephone

I deliver the medicine(s) described below to **St. Paul's Catholic School** *to be held for use by my child in accordance with the instructions given below. I consent and authorize the person designated by the School to dispense and to supervise my child's self-administering the medicine(s). We/I understand that the School assumes no responsibility for the instructions we/I have provided below, other than to allow my child to self-administer the medicine(s) and we/I assume all risk associated with the child's taking such medicine(s).*

We/I understand that under the provision of Florida Statute 232.46, school personnel cannot be held liable for reactions or side effects from the administration of the medication(s). We/I also grant permission for school personnel to contact the physician if there are questions or concerns about the medication(s).

______________________________ (______)____________ (______)____________
Date ***PARENT/GUARDIAN*** Signature Home Phone Emergency Phone

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The following is to be completed by the **PHYSICIAN**:

Diagnosis for which medication is given: ______________________________

Name of Medicine______________________________

Form ______________________________

Dose ______________________________

If medicine is to be given DAILY, at what time?______________________________

If medicine to be given "WHEN NEEDED," describe indications: ______________________________

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How soon can it be repeated?______________________________

Is child authorized to medicate herself/himself?______________________________

List significant side effects: ______________________________

Length of time this treatment is recommended: ______________________________

Other information: ______________________________

______________________ ______________________________
Date Physician Signature

St. Paul's Catholic School Student Medication Log

Name
Medication
Home Phone #
Mom's Work
Alternate

Teacher
Dosage
Time
Dad's Work
Alternate

Date	Time	Initials

Date	Time	Initials

St. Paul's School Clinic

Parent Permission for Administration of Medication

NAME	
DOB	
TEACHER/GRADE	
DOCTOR	
PHONE #	
MEDICATION	
DOSAGE	
DATE OF PRESCRIPTION	
PRESCRIPTION NUMBER	
TIME TO BE ADMINISTERED	

I, ______________________________-(Parent/Legal Guardian Name) grant permission for the principal or the principal's designee to assist in the administration of prescribed medication for my child/legal ward, ____(student name).

I certify that the prescribed medication is in its original container and that it is necessary, according to my doctor's instructions, for this medication to be provided during the school day, including when my child is away from school property on official school business. I understand that this medication will be given only according to the direction on the label as prescribed by the doctor.

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Signature of Parent /Legal Guardian Date