

**SCHOOL MEDICATION
PARENT AUTHORIZATION**

STUDENT INFORMATION

Student's Name _____

Grade _____ Teacher _____ School Year _____

List any known drug allergies/reactions _____

Height (inches) _____ Weight (lbs) _____

Name of Medication(s) _____

Reason for Taking _____

Dosage _____ Route _____

Frequency/Time(s) to Be Given _____

Begin Medication _____ Stop Medication _____
Date Date

Special Instructions:

Does medication require refrigeration? Yes No

Is the medication a controlled substance? Yes No

If asthma inhaler do you recommend this medication be kept
"on person" by the student? Yes No

Potential Side Effects/Adverse Reactions:

Treatment Order in the event of an adverse reaction:

PARENT AUTHORIZATION

I authorize the school personnel of Seton Catholic School the task of assisting my child in taking the above medication. I understand that additional statements will be necessary if the dosage of medication is changed.

Medication must be registered with Seton Catholic School office personnel. It must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the drug's expiration when appropriate.

Signature of Parent or Guardian

Date

I authorize and recommend self-medication of asthma inhaler by my child. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, and the agents of the school against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent or Guardian

Date

If any questions or problems arise, call me at (H) _____ (W) _____

(C) _____

