MEDICATION AUTHORIZATION FORM

Child's Name _____
(please print)

The parent must fill in the seven numbered areas before any medication will be administered to their child. There must be a signature for each time the medication is to be given. Prescription drugs must have the doctor's prescription attached.
I hereby authorize PSJPII CATHOLIC ACADEMY to administer the following medication to my child.

Complete by parent							Complete by school	
1) Date	2) Child's Name	3) Doctor's Name	4) Name of Medication	5) Parent's Signature	6) Dosage	7) Time to be given	Actual time given	Given by

First initial and your last name should be noted for accuracy.
New medication form will be issued as needed.
No medication is given without all the procedures being followed!
Absence of child and medication not administered--please note N.G. (not given)

Pope Saint John Paul II Catholic Academy

MEDICATION AUTHORIZATION FORM

If your physician requires medication to be administered to your child during the school day, please complete this form and return it to the school office. Pope Saint John Paul II Catholic Academy (PSJPII) cannot administer medication to your child without this completed form.

STUDENT NAME: _____ **GRADE:** _____

I hereby give permission for PSJPII Catholic Academy employees to administer the following medication to my child/ward in accordance with the written instructions from the physician. I agree to provide all medication in the original container from the pharmacy directly to the school office. I also agree to inform my child/ward's teacher of any prescription inhalers and/or anaphylactic auto injectors (EpiPens) that my child/ward will need to bring to class. I understand that PSJPII Catholic Academy and their employees are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the administration of these medications.

Parent/Guardian Signature: _____ Date_____

The following medication is to be completed by the student's physician

Medication: _____

Dosage: _____ Time(s) to be taken: _____

Number of days: From: _____ to _____

Route to be taken: _____

Reason for Medication: _____

Side effect(s): _____

Physician Signature_____ **Date:** _____

Address: _____ **Phone:** _____