St. Mary Catholic School
Medication Prescriber/Parent Authorization Form

Permission Form For Prescribed Medication And All Over-the-Counter Medication (Including Ointments And Creams)

Student Name: _____ DOB _____ Grade _____ School Year **2020-2021**

To be completed by physician/licensed prescriber:

Medication Name	Dose	Time To Be Given	Form of Medication	Side Effects

Reason for medication: _____

List minimal frequency between doses if PRN/as needed: _____

If PRN, list symptoms/condition under which medication is to be given: _____

SPECIAL INSTRUCTIONS: _____

Inhaler Use: This student is capable of self administration: Yes ___ No ___

_____ _____ _____
Physician Signature Date Printed Name

Physician Phone # _____ Address _____

_____

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TO BE COMPLETED BY PARENT/GUARDIAN

I request and give permission for (name of Child) _____ to receive the above medication at St. Mary School according to standard school policy and for the physician/staff and school staff to share information needed to assist my child with medication needs. **The school requires parent/guardian to bring medication in the original container to the school.**

_____ _____ _____
Parent/Guardian Signature Date Phone Number

School Use ONLY: Date Received: _____