## AUTHORIZATION FOR MEDICATION FORM 2016-2017

PARENTS: Please complete this form with any prescription or over the counter medicine your child may need during the 2015-2016 school year. (This even includes cough drops.) We are not permitted to dispense medicine without this completed form. Medicines are to be provided by parents as noted except for minor first aid treatments.

Student Name_____ Grade_____

## PART 1 – NON-PRESCRIPTION MEDICATION / FIRST AID MEDICATIONS AUTHORIZATION – TO BE COMPLETED BY PARENT AND SIGNED BY PHYSICIAN

We hereby request that **St. Peter School**, through its appropriate personnel, administer a medication to our child as approved by our physician, as described below. I/We further hereby release and hold harmless, St. Peter School and its employees, from any liability for injury or damages as a result of such administration of medicine.

Place a checkmark next to the medication your child may take / be treated with:

___ Tylenol, Acetaminophen, non-aspirin-dose will be age appropriate *(provided by parent as needed)*
___ Motrin, Advil, Ibuprofen-dose will be age appropriate *(provided by parent as needed)*
___ Over the counter cough medicine *(provided by parent as needed)*
___ Benadryl pills or liquid for reaction to bug bites/stings, seasonal allergies, or severe itching as necessary. May cause drowsiness *(provided by parent as needed)*
___ Cough Drops unrelated to a more serious illness *(provided by parent as needed)*
___ Anbesol or Orajel for toothaches or mouth ulcers
___ Neosporin, Bactine, or anti-biotic spray for small wounds after they have been cleaned
___ Calamine Lotion / Benedryl Gel for bug bites or minor itchy rash
___ Rolaids/Tums-dose will be age appropriate

_____ _____ _____
Date Parent/Legal Guardian Signature Licensed Medical Physician Signature

## PART 2 – PRESCRIPTION MEDICATION AUTHORIZATION – TO BE COMPLETED BY AND SIGNED BY PHYSICIAN

I hereby request that **St. Peter School** allow its appropriate personnel to administer the following *prescription* medication which I have prescribed, as follows:

- Child's name: _____
- Diagnosis for which medicine is given:_____
- Name of medication: _____
- Time to be administered: _____Dosage: _____
- Possible side effects: _____
- Termination date for administering the medication: _____

_____ _____
Date Licensed Medical Physician's Signature

***In addition to having this form completed and signed by a licensed medical physician and the parents, a signed parent note indicating the time and dosage amount is still required to give medication at the time it is needed.***

**Please note: This record will be kept on file during the 2016-2017 school year.**