

St. Basil Catholic School

Authorization for Administration of Prescription and OTC Medication by St. Basil School Personnel

PHYSICIAN/PROVIDER ORDER

Date _____

Name of Student _____ Grade _____

Home Address _____ D.O.B. _____

Condition for which the medication is needed to be administered during school hours

Medication dose, quantity, frequency, route: _____

Time(s) of administration _____ a.m. _____ p.m. _____ lunch

Medication shall be administered from Today to: End of school year

Start date _____ to: End date _____

Side effects to look for:

If there are side effects, plan for management: _____

For inhalers or insulin: is the child sufficiently responsible to permit unsupervised self-administration of medication? Yes No

May the child omit this medication during a field trip? Yes No

Medical Provider: _____

Name (print)

Signature of Medical Provider

Address

Phone

Authorization by Parent/Guardian for the administration of the above medication by school personnel:

To St. Basil Catholic School Personnel: I request that the above medication, ordered by his/her medical provider for my child, _____, be administered by St. Basil Catholic School personnel. I understand that I must supply the school with prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist and will provide no more than 26 school day supply. I understand that his medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

I understand that school officials may not be held liable for reactions if medication is administered per these directions and at request of appropriate guardian.

Name (print): _____

Signature _____ Relationship to child: _____

Phone: _____ Date _____