ST. JOHN BREBEUF SCHOOL
Authorization for Administration of Medication
(To be completed by parent)

Date: _____

Student information

Name: _____ Homeroom: _____

Medical information

Name of prescribing physician: _____

Name of medication, dosage, time of administration, duration and any other relevant information:

_____

_____

_____

Parent authorization

I understand the following:

- The authorization to administer medication indicated above.
- **The pharmacy label must be on the medication device.**
- The parent is responsible for replacing expired medication as well as the removal and disposal of expired medication.

I hereby request and authorize the school to administer the medication named above to my child as outlined above.

Parent signature: _____ **Date:** _____

School administrator signature: _____ **Date:** _____