St. John Brebeuf School

PERMISSION TO ADMINISTER MEDICATION

If your child has a chronic condition that requires medication on a daily basis, or on a periodic basis and you wish to leave medication at the school so your child will have access to it as needed, please complete the form (both sections) below. Medication must be in its original container with the medical label and dose information on it.

Student Name _____

Student's Address _____

Birthdate _____ Medication _____

When to be given and how much: _____

_____

_____

_____

I hereby request and authorize that my child be given medication as prescribed by our doctor. Such medication is to be given by the school's designated personnel. This authorization is considered to be valid until June 30th next following this date, unless withdrawn by the doctor or parent(s)/guardian(s).

Parent/Guardian Name _____ _____
(Please Print) *(Relationship to Student)*

_____ _____
Date *Signature of Parent(s) / Guardian*(s)

AUTHORIZATION BY DOCTOR TO ADMINISTER MEDICATION

I hereby give permission for this child to be given the following medication at school. Such medication is to be given by the school's designated personnel. This authorization is considered to be valid until June 30th next following this date, unless withdrawn by parent/guardian or doctor.

PLEASE SUPPLY NAME OF DRUG, THE DOSAGE TO BE ADMINISTERED, THE TIME OF DAY IT IS TO BE GIVEN, POSSIBLE SIDE EFFECTS, AND REASON FOR MEDICATION TO BE GIVEN.

_____

_____

_____

_____

Name of Doctor _____
(Please Print)

_____ _____
Signature of Doctor *Date*

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