# ST. JOAN OF ARC CATHOLIC SCHOOL
# MEDICATION AUTHORIZATION for 2016-2017

Student _____ Grade _____ Age_____

## PHYSICIAN DIRECTIONS

Medication to be given _____
Dosage _____ Route _____ Time _____
Starting Date _____ Termination Date _____
Purpose of medication _____
Possible side effects/observations to note _____
Physicians request comments from school? Yes _____ No _____
This medication may be safely given by school personnel who have been properly trained.

_____ _____ _____
Physician Signature Phone Date

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I request the student above receive the medication as ordered by the physician while in school and school related activities. I understand it is my responsibility to furnish the medication in the original container or prescription bottle appropriately labeled by the pharmacy or physician stating name of medication, dosage and instructions. I accept the responsibility of monitoring the action and side effects of the medication and ask that I be notified if the following occurs:

_____

_____

_____ _____
Parent/Guardian Signature Address

_____ _____ _____
Home Phone Cell Phone Work Phone

Complete this section in addition, ONLY if medication is P.R.N. (when necessary)/as needed:

Medication should be provided when: _____
Notify if/additional instructions: _____
I find the following school personnel competent to provide the medication stated above.
_____

_____ _____
Parent/Guardian Signature Date