

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: _____

Birth Date: _____

School: _____

Grade: _____

THIS PORTION TO BE COMPLETED BY THE PHYSICIAN/DENTIST

<u>Name of Medication</u>	<u>Dosage</u>	<u>Methods of Administration</u>	<u>Time of Day to Be Taken</u>
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If given prn specify the length of time between doses _____

Inhalers: _____

Indicate if student must carry on his/her person

Epi-Pen: _____

Indicate if student must carry on his/her person

Possible side effects of medication _____

Emergency procedure in case of serious side effects _____

☐ I request and authorize that the above-named student be administered the above- identified medication in accordance with the instructions indicated above from _____ to _____ (not to exceed current school year) as there exists a valid health reason, which makes administration of the medication advisable during school hours.

Date of Signature

Physician/Dentist Signature

Telephone Number: _____ Name: _____

Print or Type

Please Note: If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request/authorize the school to administer medication to the above identified student in accordance with the doctor's instructions for the period from _____ to _____ (not to exceed current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner.

Permission to carry inhaler and/or Epi-Pen (please select): inhaler Epi-Pen

I _____, agree on behalf of myself, my heirs, successors, assigns, executors, and personal representatives, to hold harmless (Name of School), its administration, teachers and staff, and the Corporation of the Catholic Archbishop of Seattle, or representatives associated with the event from any and all actions, claims, demands, damages, costs, expenses and all consequential damage arising from or in connection with administering medication or in connection with any illness or injury or cost of medical treatment in connection therewith, and I agree to indemnify the school, its administration, teachers and staff, and the Corporation of the Catholic Archbishop of Seattle, or representatives for reasonable attorney's fees and expenses arising therewith.

Date of Signature

Parent/Guardian Signature

Telephone number: _____ (home) _____ (work)