SACRED HEART SCHOOL

RELIGION ♥ ACADEMICS ♥ ATHLETICS

MEDICATION AUTHORIZATION

Student Name: _____ **Student is in Grade:** _____

Parent/Guardian Name: _____ **Phone:** _____

If at any time during the school year it becomes necessary for a student to take medication (either prescribed or over the counter medicine) during the school day, this parent/guardian request form to administer the medication to the student must be completed and on file in the Principal's office. The pharmacy label can serve as the written consent of the physician.

I request that the medication described below be administered to my child at the times specified during the school day at **Sacred Heart School** (322 W Maple St, Lombard, IL 60148). I will provide the principal/school nurse with this medication in a container provided by the pharmacist. I understand that this medication will be dispensed to my child only by the school nurse, Principal, or office personnel; and that the medication will be kept secure in a locked cabinet or refrigerator. I understand this consent is valid for one school year and must be renewed annually or whenever there is a change in medication.

_____ _____

Parent/Guardian Signature **Date**

Name of medication, dosage & time(s) of Administration along with any instructions for administration:

Type of Medication:

- ☐ Prescription
- ☐ Over the Counter (Requires Physician Signature)

Refrigeration Required?:

- ☐ YES
- ☐ NO

Start Date to give Medication: _____ **Date to end administering:** _____

Purpose of this Medication:

Physician's Name: _____ **Physician's Phone:** _____

Date: _____

_____

Physician's Signature

Pharmacy Name: _____ **Prescription#** _____

Pharmacy Name: _____ **Prescription#** _____