

*St. Joseph's Catholic School
11011 Montgomery Road
Beltsville, MD 20705*

**Physician's Authorization for Medication Administration of
Prescription Drugs (One Drug Per Form)**

FOR COMPLETION BY PARENT OR LEGAL GUARDIAN

Full Name of Student _____
School Year _____ **Grade** _____

- I understand that I must supply the school with the equipment/supplies to administer any medications my child must take
- I understand that all medications must be in the original bottle/vial/blister pack or other original container. Prescription medications will only be accepted with the prescription label prepared by a registered pharmacist. The information should clearly state the name of the child; the name of the medication with appropriate dosage, frequency, route of administration; the intended purpose of the medication (i.e., for pain, etc.) and the name and phone number of the prescribing physician.
- I hereby authorize the administration of the stated medication by the School RN or the Certified Medication Technician, as directed by my child's physician.
- I understand that the physician will be contacted, if there are any questions about the medication
- I understand that 911 will be called immediately in an emergency

Signature of Parent/Legal Guardian **Printed Name of Parent/Legal Guardian**

Date

FOR COMPLETION BY PHYSICIAN OF ABOVE NAMED STUDENT

1. **Name, Dosage, Route of Medication** _____
2. **Reason for Medication** _____
3. **Time/Frequency of Medication** _____
4. **Start Date** _____ **Completion Date** _____
5. **Possible Side-Effects** _____
6. **Additional Information (Crush, dissolve, give with food/milk, etc.)** _____

7. **Known Food/Medication Allergies** _____

Physician's Signature (Original – NO STAMPS) **Date**

Physician's Printed Name **Physician's Telephone Number**
Physician's Address

Reviewed by RN _____ / _____
(Name/Date)