

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

Physician's Non-Prescription Drug Authorization

FOR COMPLETION BY PARENT OR LEGAL GUARDIAN

Full Name of Student _____
School Year _____ Grade _____
Known Medication or Food Allergies _____

No medication will be administered by the RN or designated Certified Medication Technician, without the prior authorization of the student's Physician and the consent of the parent or legal guardian. Medications will be administered during the school day **ONLY WITH THE PRIOR WRITTEN CONSENT CONTAINED IN THIS FORM.**

FOR COMPLETION BY THE STUDENT'S PHYSICIAN—PLEASE PRINT

I _____ authorize the administration of the following non-prescription medications to the above-named student, by the School RN or designated Certified Medication Technician. **NO OTHER SCHOOL PERSONNEL ARE AUTHORIZED TO ADMINISTER ANY MEDICATIONS EXCEPT IN LIFE/DEATH EMERGENCIES!** The dosages of the (*) medications must be specified.

<input type="checkbox"/> Tylenol (or Generic)*	<input type="checkbox"/> Ibuprofen*	<input type="checkbox"/> Tums	<input type="checkbox"/> Maalox
<input type="checkbox"/> Pepto-Bismol	<input type="checkbox"/> Sterile Eye Wash	<input type="checkbox"/> Hydrogen Peroxide	<input type="checkbox"/> Sucrets
<input type="checkbox"/> Cough Drops	<input type="checkbox"/> Calamine Lotion	<input type="checkbox"/> Neosporin	<input type="checkbox"/> Betadine
<input type="checkbox"/> Oragel (or Generic)	<input type="checkbox"/> Mouthwash	<input type="checkbox"/> Rubbing Alcohol	<input type="checkbox"/> Benadryl*
<input type="checkbox"/> _____ (Other - Please Specify)			
<input type="checkbox"/> _____			

(Dosages for (*) medications checked above)

FOR COMPLETION BY PHYSICIAN AND PARENT/GUARDIAN

I understand that all medications, prescription and non-prescription, must be hand-delivered to the school with the proper labels and authorizations, in the original packaging. **THEY MUST BE GIVEN TO THE SCHOOL RN or CERTIFIED MEDICATION TECHNICIAN.** UNDER NO CIRCUMSTANCE WILL ANY MEDICATIONS, PRESCRIPTION OR NON-PRESCRIPTION, BE ADMINISTERED WITHOUT THE PRIOR PHYSICIAN AUTHORIZATION AND PARENT/LEGAL GUARDIAN APPROVAL. UNDER NO CIRCUMSTANCE MAY A STUDENT HAVE ANY MEDICATION, PRESCRIPTION OR NON-PRESCRIPTION, IN HIS/HER POSSESSION, NOR MAY THEY BE SELF-ADMINISTERED.

Physician's ORIGINAL Signature (NO STAMPS) _____ (Date) _____

Physician's PRINTED NAME _____

(Signature of Parent or Legal Guardian) _____

(Printed Name of Parent or Legal Guardian) _____