Queen of Peace Catholic School

Authorization to Administer Medication 2016-2017

Student's Name_____ Birthdate_____

Address_____ Phone Number_____

Name of Parent/Guardian _____

Parental Release
I request and authorize designated school personnel to give the following medication to my child as prescribed by a physician. I release school personnel from any liability should reactions result from the medications. I authorize the school nurse to contact the prescribing physician's office and allow his/her office to disclose the necessary information regarding this/these medications.

_____ _____
Parent Signature Date

Note: All medication must be in original container, properly labeled, including a recent date.
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To be completed by physician:

Medical Diagnosis_____

Name of Medication	Dosage	Time to be Given
_____	_____	_____
_____	_____	_____

Side effects of medication _____

It is acceptable for student to carry inhaler on self and self-administer as directed:
(Inhaler use ONLY) _____ YES _____NO

_____ _____
Physician Signature Date

_____ _____
Clinic Address/Phone