St. Matthew School Authorization and Permission for Administration of Medication

____________________________________ ___/___/___ __________
Student's Name (Last) (First) (Middle) Birthdate Date

School medications and health care services are administered following these guidelines:

- Parent signed, dated authorization to administer the medication.
- The medication is in the original labeled container as dispensed or the manufacturer's labeled container.
- The medication label contains the student name, name of the medication, directions for use and date.
- Annual renewal of authorization and immediate notification, in writing, of changes.

Medication/Health Care Dosage Route Time at School

Administration Instructions

Discontinue/Re-Evaluate/Follow-up Date

Prescriber Date

Prescriber's Address Emergency Phone

I request the above student be given the medication at school and school activities by qualified staff, according to the prescription or nonprescription instructions and a record maintained. The student has experiences no previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and the medication information may be shared with school personnel who need to know.

I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonable prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.

Parent's Signature Date

Parent's Address Home Phone

Additional Information Business Phone