McDONELL AREA
CATHOLIC SCHOOLS
Est. 1882

AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION BY SCHOOL PERSONNEL

School *(check one)*

☐ St. Charles Borromeo Primary School
☐ Notre Dame Middle School
☐ Holy Ghost Elementary School
☐ McDonell Central Catholic High School

Name of student: ____

Address: ____

City: _______________________________ State: _______ Zip: _______________ Phone: __________________

Parent/Guardian

I, ____, request that the school personnel administer
(Parent/Guardian)

to ____ in ________ grade the medication prescribed
(Student)

by ____.
(Physician)

____ ____________________________
(Signature of Parent/Guardian) *(Date)*

Family Physician

This is to certify that ____, identified above, is a patient of mine. It is essential that he/she be given the following medication in the dose indicated during school hours.

TYPE OF MEDICATION:	**PURPOSE:**
DOSAGE:	**FREQUENCY:**
POSSIBLE SIDE EFFECTS:	
LENGTH OF TIME TO BE GIVEN: **_____ Indefinitely _____ To be renewed _____ To be discontinued**	

____ ____________________________
(Signature of Physician) *(Date)*

____
(Address)

NOTE: It is the parent's responsibility to see that the school personnel receive this authorization. No medication will be given at school without the signed consent of the parent, or for prescription medications, parent and physician.