McDONELL AREA CATHOLIC SCHOOLS
Est. 1882

AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION BY SCHOOL PERSONNEL

School *(check one)*

☐ St. Charles Borromeo Primary School
☐ Holy Ghost Elementary School
☐ Notre Dame Middle 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.