All Saints Catholic Academy MEDICATION ORDER

ONE FORM PER MEDICATION School Year:

Student's Name: DOB: Grade:

Address: Phone:

TO BE COMPLETED BY PHYSICIAN

Medication: Dose: Route:

Frequency:

Indication: Side Effects

Duration of Order: Current School Year or other: (specify duration)

Prescriber's Name/Title:

Address:

Prescriber's signature: Date:

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded.

Parent/Guardian Signature: Date:

Home phone: Cell phone: Work phone:

This form must be completed fully in order for school to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber. • Non-prescription medication must be in the original container with label intact, unopened.
- An adult must bring the medication to the school.