St. JEROME
CATHOLIC PARISH AND SCHOOL

AUTHORIZATION FOR MEDICATION

Name of Student: ____ Grade:___________
School: ____
Phone Number: _______________________Fax Number:______________ Date: __________

MEDICATION TREATMENT PLAN TO BE COMPLETED BY PHYSICIAN

Diagnosis: ____

Medication, Dosage, Specific Time and Direction for Administration (Please write each medication, dosage, frequency and time separately):

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NOTE: Medication must be supplied in the original prescription container. Ask pharmacists to divide the medication into two completely labeled containers, providing one for home and one for school.

Side Effects/Special Instructions:

NOTE TO PHYSICIANS:Please complete the treatment plan on the back of this form for students who require any special health procedures during school hours, (ie:inhalers,nebulizer treatments,catheterization,suctioning,tube feedings,glucose testing,etc.)

Printed Name or Stamp Physician: ____
Physician's Signature: ____
Physician's Phone Number: ____
Physician's Fax Number: ____

PARENTAL PERMISSION TO BE COMPLETED BY PARENT/GUARDIAN

I grant the principal or designee the permission to assist in the administration of each prescribed medication/procedure to be provided during the school day, including when (Student Name):_________________ is away from school property on official school business.

Signature of Parent:____
Home /Cell Phone Number:____
Work Phone Number:____

St. JEROME
CATHOLIC PARISH AND SCHOOL

TREATMENT FOR STUDENT NEEDING HEALTH PROCEDURES DURING SCHOOL HOURS

Treatment Plan:____

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Special Procedures (List special procedures in which students have been trained (ie: insulin administration, use of Epi-Pen, nebulizer, testing glucose levels, etc.):

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Please list any limitations that should be considered (ie: physical education, outdoor activities, etc.)____

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Please state the emergency precaution that should be considered (ie: allergy triggers, diabetes reaction, etc.)____

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Physician's Signature:_______________________________________ Date: _______________