ACADEMY OF THE HOLY NAMES
Parental Authorization for Administration of Prescription or Over-the-Counter Medicine at School
****A new form is required yearly ****
***Required Fields**

*Date: ______________________ *Student's Name: ____ *Birth Date:______________________

*Grade: ________________________ *Homeroom or Teacher: ____

*Medication Allergies____ Student's Weight: ________________

Fill out this portion of the form for all <u>prescription</u> medication:

Name of **Prescription Medication**: ____ Dose: _________________________________

Date to Start: ________________________________ To End: _______________________________ Time to be given: _______________________________

Health Condition Requiring Medication: ____

Possible Side Effects/Special Instructions: ____

PARENT/GUARDIAN SIGNATURE REQUIRED AT BOTTOM OF FORM

I understand that under provisions of Florida Statute 232.46, school personnel cannot be liable for reactions or side effects from the administration of the medication.
I also grant permission for school personnel to contact the physician if there are questions or concerns about the medication.
I have read the guidelines and agree to abide by them.

All medication must be sent in to school in the original pharmacy container, labeled with the student's name. All prescription medication must have the pharmacy label attached.

OVER-THE-COUNTER MEDICATIONS

Fill out this portion of the form for <u>over-the-counter medication.</u>

The clinic keeps a limited selection of over-the-counter medications in stock which you will find listed below. If you would like your child to be able to receive these medications at school when necessary, you must complete this permission form. The **form must be signed by <u>you</u> and your <u>physician</u>. You must also supply all over-the-counter medication that is not on the list of medications stocked in the clinic.**

Name of Medication(s)	Dosage	Special Instructions
Tylenol/Ibuprofen		
Benadryl		
Mylanta/Tums		
Throat Lozenges		
Cough Drops		
Hydrocortisone Anti-Itch Cream 1%		
Antibiotic Ointment		
Antiseptic Spray		
Midol		
**Other		

*(**to be supplied by the parent)*

IF SYMPTOMS PERSIST FOR MORE THAN 24 HOURS, THE STUDENT WILL BE REFERRED TO HIS/HER PHYSICIAN.

*____

***PHYSICIAN/DENTIST SIGNATURE (<u>required for any over-the-counter medication</u>) Date**

AS THE PARENT/GUARDIAN, I HAVE ADVISED THAT THE ABOVE NAMED STUDENT MAY USE THE MEDICATION(S) OR TREATMENT(S) AS INDICATED. SHOULD THERE BE ANY CHANGE IN MEDICATION(S)/DOSAGE OR TREATMENT(S) I WILL ADVISE BY FILLING OUT A NEW FORM.

***I GIVE MY PERMISSION FOR AHN/THE SCHOOL NURSE TO ADMINISTER THE INDICATED MEDICATION(S) TO MY CHILD.**

*____

***PARENT/GUARDIAN SIGNATURE (<u>required for over-the-counter and prescription medication</u>) Date**

*Home Phone: ______________________________ *Work Phone: ______________________________ *Cell Phone: ______________________________