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 Height: _____ Student's Weight: _____

Name of **Prescription Medication**: _____ Dose: _____

Time to be given: _____ or Every_____Hours

Date to Start: _____ To End: _____

Health Condition Requiring Medication: _____

Possible Side Effects/Special Instructions: _____

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.

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_____TO ADMINISTER THE INDICATED MEDICATION(S) TO MY CHILD.** **School/Individual**

*_____
*Parent/Guardian Signature (REQUIRED FOR OVER-THE-COUNTER AND PRESCRIPTION MEDICATION)

*Home Phone: _____ *Work Phone: _____*Cell Phone: _____

The above is to be used for all <u>prescription</u> medication and for all over-the-counter medication that is <u>not listed</u> on the Over-the-Counter Medication form below. 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. You must also supply all over-the-counter medication that is not on the list of medications stocked in the clinic.

<u>Clinic Policy for Over-the-Counter Medications</u>

The clinic keeps a limited selection of over-the-counter medications in stock which you will find listed on the **Administration of Over-the-Counter Medication(s) at School Form** 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>.**

ADMINISTRATION OF OVER-THE-COUNTER MEDICATION(S) AT SCHOOL

Name of Medication(s)	Dosage	Special Instructions
Tylenol/Ibuprofen		
Benadryl		
Mylanta/Tums		
Throat Lozenges/Cepacol		
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