

St. Therese Catholic School
430 South Main Street
Wayland, MI 49348
269 - 792 - 2016

Authorization for Administration of Medication by School Personnel

PHYSICIAN / PROVIDER ORDER

Date _____

Name of Student: _____

Grade: _____

Address: _____

D.O.B. _____

Condition for which the drug is needed to be administered during school hours: _____

Drug (dose, quantity, frequency, route): _____

Time(s) of administration: _____ at lunch

Medication shall be administered from: today to: end of school year
 start date _____ end date _____

Side effects to look for: _____

If there are side effects, plan for management: _____

For inhalers or insulin: is the child sufficiently responsible to permit unsupervised self-administration of medication?
 yes no

May the child omit this medication during a field trip? yes no

Medical Provider: _____
Name (print) Signature of Medical Provider

_____ Address Phone

Authorization by Parent/Guardian for the administration of the above medication by school personnel:

To School Personnel:

I request that the above medication, ordered by his/her medical provider for my child _____
_____ be administered by school personnel. I understand that I must supply the school with
prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist and
will provide no more than 26 school day supply. I understand that this medication will be destroyed if it is not
picked up within one week following termination of the order or one week beyond the close of school.

I understand that school officials may not be held liable for reactions if medication is administered
per these directions and at request of appropriate guardian.

Name (print): _____

Signature: _____ Relationship to child: _____

Phone: _____ Date: _____