

St. Mary's School Medication Authorization Form

Name: _____ Birth Date: _____

Physician: _____
Print Name Address Telephone

As the parent/guardian, I understand that it is the policy of St. Mary's School that as a regular and normal practice, medication should not be administered to a student at school or when such student is involved in school activities. However, in order to provide for the critical health and well-being of students, under exceptional circumstances, medication may be administered during school hours by a certified school nurse, a registered nurse, administrative personnel, administrative designee, or self-administered by a student. I further release St. Mary's School and individual members thereof, and its employees shall be indemnified and held harmless from any and all claims arising out of administration of said medication.

I request that my child be assisted in taking the medication(s) described below at school by authorized persons or be permitted to medicate himself/herself as also authorized by me and my physician (see below). I further consent to the sharing of relevant medical information between the school and the physician's office.

Date Parent/Guardian Signature Home Phone Emergency Phone

The following section MUST be completed by the PHYSICIAN.
 All items must be completed before the school will approve administration of medication

Medication	
Time to be administered	
Dose	
Start date	
Stop date	
Purpose/Diagnosis	
If "as needed", describe indications	
How soon can dose be repeated	
Medication side effects	
Other medications student is taking	

Is child authorized to self-medicate? Yes No

Is the administration of this medication necessary during school hours in order to allow the child to attend school or to address the student's medical condition that may arise at school? Yes No

Date Physician's Signature/Stamp Physician's Telephone

To be completed by St. Mary's Principal: Approved: _____ Not Approved: _____

Reason if not approved: _____

Principal's Signature: _____ Date: _____

Date Medication picked up: _____ Date Medication destroyed: _____

Signature If Destroyed: Principal: _____ Witness: _____