Villa Maria Academy High School

AUTHORIZATION TO GIVE MEDICATION AT SCHOOL

****This form must be completed and sent to the School Nurse if your child needs to be given medication during the school day. This includes **all** prescription medications and **all** over-the-counter (OTC) medications (OTC examples: cold/allergy medications, vitamins, herbal supplements.)****

Student's name: ____ Grade: ________________________

Date of birth: _______________________ Allergies: ____

List of medications currently being taken by the child:____

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PARENTAL PERMISSION

I, the parent/guardian of ______________________________________ request that the School Nurses of Villa Maria Academy High School administer the medication named below. I understand that I must give the first dose of this medication at home, and that all medications must be sent in their original pharmacy containers along with signed physician authorization to administer the medication in school. My signature on this document constitutes a complete waiver of liability claim in any and all respects against Villa Maria Academy High School and all of its employees unless the School is negligent with regard to any claim for injury in connection with administration of the medication named below.

I understand that all medications, unless indicated in writing by the physician, must be kept at the Nurse's office and that my child may not carry medication on his/her person during the school day, nor may it be kept in his/her school bag.

Additionally, I agree to provide the medication to the school in the original pharmacy or physician labeled container. If I am unable to deliver it, I will place the container containing the medication with this completed authorization form in a sealed envelope for transport to the school. **I also accept responsibility to provide a physician's note and my written consent if the medication is to be changed or discontinued.** I give permission for the school and our child's physician to communicate regarding this medication/medical condition.

____ __________________________ __________

Signature of Parent/Guardian **Daytime Phone Numbers** **Date**

****A new authorization form must be signed (Parent & Physician) each school year****

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PHYSICIAN AUTHORIZATION FOR MEDICATION-To be completed by physician

******Medications will not be given without physician's signature******

Name of medication: ________________________________ Route of administration: ________________________

Dose: ____

Time to administer: _____________________________ Discontinuation date: _______________________________

****Asthma inhaler: The student is qualified and able to self-administer the inhaler and may carry the inhaler during the school day per School Policy. YES NO NOT APPLICABLE*

Treatment of: ____

Side effects: ____

____ ____

Physician Signature **Printed Name of Physician**

____ ____

Date **Physician Phone Number**