Catapult Learning

Medication Authorization During School Hours

DOCTOR FILLS IN REQUIRED SECTIONS. Parents sign and return completed form to the school nurse. This form is <u>required</u> for over-the-counter or <u>prescription medication</u> administered in school. Please do not make any changes to this form

STUDENT: ______________________ GRADE: ______________

DATE OF BIRTH: ______________________ HOME PHONE: ______________

Medication taken at home YES: __________ NO: ________

Name of Medication(s) taken at home: ______________________________

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The following **<u>prescription medication</u>** may be administered to my patient:

MEDICATION: ______________________ DOSAGE: ______________

TIME TO BE GIVEN: __________ GIVEN FOR: ______________________

SIGNIFICANT SIDE EFFECTS: ______________________________

MEDICATION: ______________________ DOSAGE: ______________

TIME TO BE GIVEN: __________ GIVEN FOR: ______________________

SIGNIFICANT SIDE EFFECTS: ______________________________

The following **<u>over-the-counter medication(s)</u>** may be administered to my patient:

Cough Drop: ________ How frequently: ______ As needed for: ______________

Tylenol: 325 mg _______ How many: ________ How Frequently: ____________
OR 160 mg _______ How many: ________ How Frequently: ____________
As needed for: ______________________

Motrin/Advil: 200 mg ______ How many: _________ How frequently: ____________
OR 100 mg ______ How many: _________ How frequently: ____________
As needed for: ______________________

Benadryl: Dosage: _________ How frequently: _________ As needed for: ____________

Doctor Name (print): ______________________ Date: ______________________

Doctor Signature: ______________________ **Doctor Stamp**:

I request for my child, ______________________, to receive medication as listed above. I have been informed that the school, its agents, and employees shall incur no liability whatsoever as a result of any untoward reaction arising from the administration of medication to my child.

Parent Name (print): ______________________ Date ______________________

Parent Signature: ____

Return this form only if you want to authorize medication administration