St. Charles Preparatory School
2010 East Broad Street
Columbus Ohio 43209-1665
614-252-6714
Fax: 614-251-6800

MEDICATION AUTHORIZATION

Student________________________ Date of Birth______ Grade_______

Address____

PHYSICIAN'S AUTHORIZATION

__________________________________ is under my care and should have
(Name of Student)

___________________________ _____________ _____________
(Medication) (Dosage) (Route)

___________ __________________________ _____________________
(Time/s) (Beginning Date of Administration) (Last Date of Administration)

Possible severe side effects to watch for__________________________________
____

Special instructions for administration or storage of medication _________________
____

Note: A new authorization must be submitted if any change is made.

Physician Signature ________________ Phone #______________ Date________

PARENT PERMISSION

I request medication be administered to__________________________________
(Name of Student)

as prescribed by Doctor ___________________ as specified above. I understand that the school authorities are not liable for administering or failing to administer this medication.

Parent/Guardian Signature ___________________________________
Date _________________ Phone # ______________________________

This form must be completed and returned to the school nurse BEFORE any medication can be administered..