Archdiocese of Baltimore

St. Augustine School

# PARENTS'S REQUEST TO ADMINISTER MEDICATION AT SCHOOL

To be completed by parent/guardian:

Name of Student_____ Date of Birth_____Grade___School Yr___
(last, first, MI)

In order for my child to receive medications in school, I agree to the following:

*All prescription and non-prescription medication will be in a container labeled by the pharmacist or physician with:

Name of child Name of Medication Dosage, route and time of administration
Name of physician Prescription date and expiration date Conditions for proper storage

*The non-prescription medication will be in the original sealed container with the label intact. Student's name will be put on the container in a position that does not obscure the label.

- An adult will bring the medication to school.
- The physician will be called if a question arises about my child's medication.
- The first dose of this medication (Except for Epi-pen) has been given without problems.

Having read the above conditions, I request St Augustine School Health Services Personnel to administer the medications as prescribed by the physician below. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school.

Signature of parent/guardian_____Date:_____
Relationship to student_____
Phone Number(H)_____(W)_____(C)_____