2019-2020
St. Michael Catholic School and Extended Care
Authorization for Administration of Medication

Child's Name:_____(**Please fill out one form for each student**) Grade:_____

Parent/Guardian:_____ Daytime Phone#:_____

I (We) as parent/guardian of the above named child authorize the personnel or a health office volunteer of St. Michael School/Extended Day Care to give my child the following **non-prescription medication** should it be necessary:

Check any non-prescription medications that you are authorizing personnel or a health office volunteer of ***St. Michael School/ Extended Day Care to administer. A phone call from*** personnel or a health office volunteer of St. Michael School/Extended Day Care will be made to the parent/guardian of above named child for verbal permission to administer medications. ***Recommended dosage on the bottle will be given.***

Ibuprofen _____ Tylenol _____ Benadryl _____
Other _____

Medical Conditions: Please list any medical conditions, allergies to medicines, and food allergies below. **Asthma/Anaphylaxis Action Plan forms are available in the school office**.

_____

_____

_____

I (We) as parent/guardian of the above named child authorize the personnel or a health office volunteer of St. Michael School/Extended Day Care to give my child the following **prescription medication(s)** should it be necessary:

Name of Medication(s):	Dosage Amount & time:	Authorization & Date:
_____	_____	_____
_____	_____	_____
_____	_____	_____

I (We) understand that all prescription medications will be sent in its ***original*** container with a proper label that includes: name of child, name of medication, dosage, route and frequency of administration, name, address and phone number of pharmacy, name, address, and phone number of prescribing physician. Also include reason for administration and possible side effects. All medications will be turned into and stored at the school health office.

I (We) understand that if this form is not signed and returned to the school office, my child will not be given any medication at School.

I hereby release the personnel and/or health office volunteer of St. Michael School/Extended Day Care from any liability arising from the administration of non-prescription and/ or prescription medication. I accept ultimate responsibility for monitoring the effects of this medication.

_____ _____
Parent/Guardian Signature Date

Medication Log

Date	Time	Reason	Temp/Medication	Dosage	Initial