HOLY FAMILY SCHOOL

PHONE: 812-944-6090
FAX: 812-944-7299

Medication Permission Form
Authorization to Give Medication in School

Child's Name: _____ Birthdate: _____ Grade: _____

Today's Date: _____ Continue Through (Date): _____

Name of Medication(s): _____

Dose & Time to be Given: _____

If prescribed on an as needed (PRN) basis, give for these symptoms: _____
_____

Side effects, if any: _____

Please indicate if this medication is:

☐ **PRESCRIPTION MEDICATION**
Is the medication in the original container or box with the prescription label and instructions?
☐ YES (Physician Authorization is not required)
☐ NO. See Physician's Authorization requirement below*. This medication may not be given unless the required information is provided.

☐ **NON-PRESCRIPTION MEDICATION**
For **all** non-prescription medications, you must provide a completed Physician's Authorization* (see below).

I hereby give permission for the administration of the medication described above by the staff of the Holy Family School, and have provided the completed Physician's Authorization if necessary.

Parent/Guardian Signature: _____ Date: _____

Parent's/Guardian's Printed Name: _____

PHYSICIAN'S AUTHORIZATION
You must provide **either** of the following forms of authorization, which must be signed by a physician:

☐ Physician's Signature: _____ Physician's Stamp: _____
☐ See attached, signed physician's authorization document

All forms are valid through the end of the school year.