



AUTHORIZATION FOR SHORT TERM/LONG TERM PRESCRIPTION MEDICATION

This form should be completed by parent/guardians who are requesting that the school assist in the administration of prescription medications such as antibiotics or daily medications.

Authorization to give long term/short term prescription medications

The Academy of the Sacred Heart requires the following:

1. A written consent form signed by the parent/guardian.
2. The medication in the original bottle labeled by a registered pharmacist. (Note: Many pharmacists will give you additional bottles with labels if requested)
3. The parent/guardian to bring the consent and medication to the school office/nurse.

Student's Last Name	Student's First Name	MI	Sex	Date of Birth	Grade
Name of Medication _____			Dosage _____		
Specific time(s) and dose(s) to be given at school _____					
Length of time _____			Why indicated? _____		

I request that the above mentioned student receive the medication(s) listed above at school according to standard school policy and for the physician/staff and school staff to share information needed to assist my child with medication needs.

The school recognizes that it may be necessary for some students to administer/carry their own medications. Self-administration means that the student can administer the medication in a manner directed by the physician without additional direction or supervision by school staff. Self-possession means that under the direction of the physician, the student may carry medication on his/her person to allow for immediate and self-determined administration.

In addition, I request and give permission for the above mentioned student to _____ self-administer or _____ self-possess the above medication(s) according to school policy and for the physician/staff and school staff to share information needed to assist my child with medication needs.

Signature Parent/Guardian _____ Date _____

TO BE COMPLETED BY THE STUDENT (if physician and parents have agreed to self-administration/self-possession of medication).

I agree to:

1. Never share my medication with another person. Endangering the health of another student by misuse or sharing of medication could result in disciplinary action.
2. Carry the medication in its original, properly labeled, prescription container.
3. Take medication only at the prescribed time/frequency and dose.
4. Be knowledgeable regarding the dose, desired effects, side effects, administration, etc. of the medication.
5. Report side effects to the school nurse/faculty/staff or my parents if they occur.

Student Signature _____ Date _____