

MEDICATION AUTHORIZATION FORM

MEDICATION RELEASE FOR PRESCRIPTION MEDICINE

Student's Name: _____ Grade Level: _____ Date: _____

A.) I hereby give my permission to the staff at Blessed Trinity Catholic School to dispense medication prescribed by Dr. _____ for my child, beginning on _____ and ending on _____.
Date Date

Name of medication or prescription number (including name of drug store):

MEDICATION RELEASE FOR NON-PRESCRIPTION MEDICINE

(Over the counter medication such as aspirin or cough syrup)

B.) I hereby give my permission to the staff at Blessed Trinity Catholic School to dispense the following over the counter medication to my child, beginning on _____ and ending on _____.
Date Date

Name of medication: _____

Please complete the following information regarding the medications listed in sections A and B.

Instruction for dispensing: _____

If there are any side affects of this medication, please indicate: _____

Further, I agree to waive any claims of liability that may arise against any school personnel relative to the administration of medication to my child, (or legal ward).

Parent's Signature _____ Date _____

This form must be on file in the school office each day any medicine is to be taken. Forms are available in the office. It is the parents' responsibility to advise the school office if the medication dose changes at any time.