Powers Catholic High School

2023-2024 Medication Administration Permission Form

Student's Name: _____ **Grade:** _____

ALLERGIES: _____

Date form received by school: _____ **Date of Birth:** _____

Name of Medication: _____

Reason for Medication: _____

Form of Medication/Treatment: (circle) Tablet Liquid Inhaler Injection Nebulizer Other

Instructions: **Dose & time** to be given at school: _____

_____

Start Date: **(Or)** Date form received _____

Stop Date: End of School Year (**or** Other date): _____

Restrictions and/or important side effect(s): _____

Special Storage Requirements: (refrigerate, etc.) _____

The student is both capable and responsible for *self-administering* this medication:

No ***Yes*** (Supervised) ***Yes*** (Unsupervised)

Student *may carry* this medication: (circle) ***Yes*** ***No***

CONTROLLED SUBSTANCES, SCHEDULE I-V, CANNOT BE HELD/CARRIED BY THE STUDENT

Physician's Signature: _____ **Date:** _____
Physician's Name: _____
Physician's Address: _____
Physician's Phone Number: _____

To be completed by the parent/guardian:
I give permission for the above medication to be given by a designated Powers Catholic employee.

Signature: _____ **Date:** _____

Relationship: _____ **Phone:** _____

*Includes prescription & over-the-counter medications, i.e. acetaminophen, Benadryl, Claritin, cough drops, ibuprofen, Neosporin, etc. **A valid and current dated form must be submitted each school year.**