BISHOP STANG HIGH SCHOOL

Authorization for Medication

(to be completed by Parent or Guardian, one per medication needed)

Student's Name: _____ **D.O.B.**: _____

Grade: _____ **Allergies**: _____

Parent/GuardianName: _____ **CellPhone**: _____

Parent/Guardian Name: _____ **Cell Phone:** _____

I give permissions for the school nurse/trained personnel to give the following medication(s):

Medication(s):_____

Dosage: _____ **Route**: _____ **Frequency**: _____

Time(s) of administration: _____ **Diagnosis:** _____

Prescribed by: _____

Other important information: _____

1. I give permission for my child to self-administer the medication(s) if the school nurse determines that it is safe and appropriate (not applicable to all medications in the school setting) : **YES NO (please make sure it is clearly stated on the accompanying order)**

2. I give permission for my child to self-administer the medication(s) according to the physician's order and instructions on the day of a field trip. If applicable my child's teacher/designee will carry the medication until needed: **YES NO (Diocese of Fall River is requiring a separate form for <u>each</u> field trip with self admin)**

3. I give permission for the school nurse (RN) to delegate to trained unlicensed school personnel to administer epinephrine (by auto-injector) to my child with a diagnosed life-threatening allergic reaction condition when the school nurse is not immediately available or on field trips: **YES NO**

4. I understand that I may retrieve the medication from school at any time and that the medication will be destroyed if it is not picked up within one week following the expiration of the order or by the last day of the school year. I understand that the school nurse may share information relative to the prescribed medication with appropriate school personnel, if determined necessary for my child's health and safety: **YES NO (If no, contact the school nurse)**

Parent/Guardian Signature: _____ Date: _____

Relationship to Student: _____