ST. DOMINIC SCHOOL
Rich in Academics † Rooted in Faith

School Medication/ Physician Order
& Parent Authorization Form

Name of Student:_____ **DOB:**_____

PHYSICIANS ORDER:

I hereby request and authorize you to give:

Medication	**Dosage**	**Duration**

Diagnosis/ medical reason for medication:_____

Other medications child is taking:_____

Side effects:_____

Physician Signature_____ Date:_____

Print Physician name:_____ Phone#_____

Clinic Name:_____ Fax#_____

Parent/Guardian Authorization

1. I request the above medication to be given during school hours as ordered by child's physician**.**
2. I release the school personnel from any liability in relation to this request when the medication is given as ordered**.**
3. Medication must be brought to school in the original container labeled (or in a labeled "blister pack") by the pharmacy. Please send only the amount the student will be taking at school to avoid having to send containers back and forth daily.
4. Medication is to be provided by me and is labeled with my student's name. I will notify the school if there are any changes regarding the time, duration, or manner of administration.
5. Students may not carry medication with them, with the exception of inhalers for asthma or epi pens.
6. If your student is carrying this type of medication, please fill out this form indicating that your student will have the medication with them and that you and your child's medical provider have evaluated his/her ability to self-administer the medication.
7. **FIELD TRIPS**: I give permission for the assigned teacher or responsible adult to administer the medication on a field trip, as necessary, following school procedure.

Signature of Parent/Guardian: _____ Date:_____