

Catapult Learning

Medication Authorization During School Hours

DOCTOR FILLS IN REQUIRED SECTIONS. Parents sign and return completed form to the school nurse. This form is required for over-the-counter or prescription medication administered in school. Please do not make any changes to this form

STUDENT: _____ GRADE: _____

DATE OF BIRTH: _____ HOME PHONE: _____

Medication taken at home YES: _____ NO: _____

Name of Medication(s) taken at home: _____

The following **prescription medication** may be administered to my patient:

MEDICATION: _____ DOSAGE: _____

TIME TO BE GIVEN: _____ GIVEN FOR: _____

SIGNIFICANT SIDE EFFECTS: _____

MEDICATION: _____ DOSAGE: _____

TIME TO BE GIVEN: _____ GIVEN FOR: _____

SIGNIFICANT SIDE EFFECTS: _____

The following **over-the-counter medication(s)** may be administered to my patient:

Cough Drop: _____ How frequently: _____ As needed for: _____

Tylenol: 325 mg _____ How many: _____ How Frequently: _____

OR 160 mg _____ How many: _____ How Frequently: _____

As needed for: _____

Motrin/Advil: 200 mg _____ How many: _____ How frequently: _____

OR 100 mg _____ How many: _____ How frequently: _____

As needed for: _____

Benadryl: Dosage: _____ How frequently: _____ As needed for: _____

Doctor Name (print): _____ Date: _____

Doctor Signature: _____ Doctor Stamp: _____

I request for my child, _____, to receive medication as listed above. I have been informed that the school, its agents, and employees shall incur no liability whatsoever as a result of any untoward reaction arising from the administration of medication to my child.

Parent Name (print): _____ Date _____

Parent Signature: _____