MOUNT SAINT DOMINIC ACADEMY

AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION/OVER-THE-COUNTER MEDICATION BY THE SCHOOL NURSE

NAME OF STUDENT_____

GRADE OF STUDENT_____

NAME OF MEDICATION, DOSAGE & FREQUENCY

1.) _____
2.) _____
3.)_____

REASON FOR USE:

1.)_____
2.)_____
3.)_____

POSSIBLE SIDE EFFECTS:

1.)_____
2.)_____
3.)_____

I herby authorize the school nurse to administer the above medication.

_____ _____
(Name of Parent/Guardian) (Signature of Parent/Guardian)

_____ _____
(Name of physician/stamp) (Signature of physician)

_____
(Physician's Address and Phone Number)

_____
(Date)