St. Gregory the Great Academy

A Ministry of the Church of St. Gregory the Great

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MEDICATION AUTHORIZATION

Appendix 5141.4
Medication Authorization

STUDENT NAME: ____

GRADE: _________________ SCHOOL: St. Gregory the Great Academy

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PART I – COMPLETED BY STUDENT'S PHYSICIAN

I certify that this school must administer medication listed below to my patient:

DIAGNOSIS: ____

MEDICATION: ____

DOSAGE/MODE/FREQUENCY: _______________________________________

POSSIBLE SIDE EFFECT: ____

PRINTED NAME OF PHYSICIAN: ________________________________

PHONE: ____________________________ DATE: ____________________

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(Physician's Signature)

PART II – COMPLETED BY STUDENT'S PARENT / GUARDIAN

I request that the medication listed above be administered to this student in school. I understand that only I, the nurse, or a school employee trained by the nurse may administer this medication in school to this student.

I acknowledge that the school shall incur no liability as a result of any condition arising from the medication. I shall indemnify and hold harmless the school, its employees or agents against any claims arising from the administration of medication by this student.

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(Signature of Parent / Guardian)