2016-2017 SMS Medication Administration Permission and Record Sheet

(one form per child per medication)

Student's Name_____Age/Grade_____Today's Date_____

Starting Date_____Stopping Date_____

Name of Medication_____

Reason for Administration_____

Is this Medication: (circle one) Over the Counter OR Prescription

***prescription medicine needs to be in the original bottle dispensed by the pharmacy with the instructions for administration on the bottle.*

***over the counter medicines must be in the original containers & dose appropriate.*

Dosage_____Time Medication to be Given_____

Route: Oral_____Nasal___left, right,both _____ Eye Drops____left, right, both

Topical_____location to be applied_____Inhaled_____

Injection_____location to be administered_____

Should Medication be Taken with Food: (circle one) Yes No Other Specific Instructions_____

Any Previously Known side-Effects_____

As the parent/guardian of this child I give my permission for the school staff of St. Monica School to administer the above medication per the above instructions. I also acknowledge that I have provided the school with the above medications in accordance with the Archdiocese policy. This can be updated every year via parent initials.

Parent/Guardian Signature_____2016-2017

2017-2018_____2018-2019_____