

Medication Administration Permission and Record sheet

Students Name: _____ Age: _____ Today's date: _____

Starting date: _____ Stopping date: _____

Name of Medication: _____

Reason for administration _____

Dosage: _____ Time medication can be given : _____

Route: oral _____, Nasal _____ left, right or both, Eye drops _____ left, right or both

Topical: Location to be applied _____ Inhaled _____

Other: _____

Should medication be taken with food: yes or no

Other specific instructions: _____

Any previously known side-effects: _____

Is this medication: over the counter or Prescription

If this medication is a prescription medication it needs to be in the original pharmaceutically dispensed and labeled container with instructions for administration.

Non-prescription medication or over the counter medications must be in the original container in which they were purchased and must be dose appropriate for the child's age.

As the parent or guardian of this child I give my permission for the school staff 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.

Parents signature: _____