Holy Family School System

PERMISSION FOR
PRESCRIPTION & NON PRESCRIPTION MEDICATION

I hereby authorize the school nurse or delegated personnel at Holy Family Schools to administer the following medication;

Student's Name ______________________________

Medication (Name)__________________________ Strength_____________

Dosage to be given each time: ______________________________________

At what hour is the dosage given at home?______________________________

At what hour is the dosage to be given at school?________________________

The above medication is to be given until:_______________________________

Health condition for which medication must be given at school:

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We must have the original medicine or prescription bottle with the medicine in it. Prescription containers must include the following information: name of medication, dosage, time to be given, name of doctor, name of student, and route of administration.

Signature____
(Parent/Guardian)

Date _______________________