NOTE: When printing this form, please select "Fit to Page" or reduce the scale to capture all the information on the page.

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: ______________________________ Birth Date: ________________

School Name: Our Lady of Fatima Parish School Grade: ___________________

THIS PORTION TO BE COMPLETED BY THE PHYSICIAN/DENTIST

Name of Medication	Dosage	Methods of Administration	Time of Day to Be Taken
____________________	_________	_________________________	__________

If given prn specify the length of time between doses ______________________________

Inhalers: ____
Indicate if student must carry on his/her person

Epi-Pen: ____
Indicate if student must carry on his/her person

Possible side effects of medication ____

Emergency procedure in case of serious side effects _______________________________

☐ I request and authorize that the above-named student be administered the above- identified medication in accordance with the instructions indicated above from
________________ to _______________ (not to exceed current school year) as there exists a valid health reason, which makes administration of the medication advisable during school hours.

__________________________________ __________________________________
Date of Signature Physician/Dentist Signature

Telephone Number: ____________________ Name: ___________________________
Print or Type

Please Note: If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I request/authorize the school to administer medication to the above identified student in accordance with the doctor's instructions for the period from August 31, 2023 - June 12, 2024 (not to exceed current school year). I understand that every effort will be made by school staff to administer the medication in a timely manner.

Permission to carry inhaler and/or Epi-Pen (please circle)

I _________, agree on behalf of myself, my heirs, successors, assigns, executors, and personal representatives, to hold harmless Our Lady of Fatima Parish School, its administration, teachers and staff, and the Corporation of the Catholic Archbishop of Seattle, or representatives associated with the event from any and all actions, claims, demands, damages, costs, expenses and all consequential damage arising from or in connection with administrating medication or in connection with any illness or injury or cost of medical treatment in connection therewith, and I agree to indemnify the school, its administration, teachers and staff, and the Corporation of the Catholic Archbishop of Seattle, or representatives for reasonable attorney's fees and expenses arising therewith.

______________________________ ___________________________________
Date of Signature Parent/Guardian Signature

Telephone number: ____________________ Email: ____________________

Over-the-Counter Medications Allowed (please check all that apply): Other(s):

Children's Acetaminophen Children's Ibuprofen Children's Antihistamine Antacid Cough Drops Sunscreen