St. Susanna School
Request Medication Administration During School Hours

I authorize the school nurse or school personnel, under the supervision of the school nurse, to be my agent to administer the following medication to my son/daughter:

Student Name: _____

Grade: _____ **Teacher/Homeroom**: _____

Name Of Medication: _____

- **Purpose/Diagnosis**: _____
- **Dose:** _____
- **Time To Be Given:** _____
    - ❖ Over the counter medication may only be given from **10AM-2PM** without parent contact.
    - ❖ **ALL MEDICATIONS** must be in their *ORIGINAL CONTAINER*, and will **ONLY** be administered per the manufacturer's directions (ie: age, and dose) unless accompanied by a Physician order.
    - ❖ If there is a *Change* in the dose or frequency of the administration of the medication; Please have the physician Fax or Phone the new prescription to the school.

Start Date: _____ **Stop Date:** _____

Parent Signature: _____**Date:** _____

Parent Name: _____**Cell #**_____ **Work #**_____

Medication must be brought into school by an Adult.

Rev 6/2017