# St. Patrick's Catholic School Medication Authorization

Student_____________________________________________ DOB___________________

Age______________ Grade______________________ School year__2024-2025___

## Directions for administration

Medication/treatment:_________________________________________________________________

Dosage:_______________________ Route:____________________ Time:_____________________

Starting date:______________________________ Termination date:_____________________________
(As indicated or end of the current school year)

Purpose of medication: _________________________________________________________________

Possible side effects/special observations to note/special instructions for administration:

_____________________________________________________________________________________

_____________________________________________________________________________________

☐ Check here if you wish to be notified prior to school staff administering this as-needed medication. (The office staff will not refrain from administering a medication if they are unable to reach a parent/guardian and determine there is an urgent need for a child to receive their medication.)

- I request/authorize the above-named student to be administered/provided the above-identified medication/treatment in accordance with the instructions as indicated while at school and in school-related activities.
- I give consent for the school to receive from or send to the Health Care Provider (HCP) any information concerning my child's medical condition and the above-named medication.
- I give consent to designated licensed and unlicensed school personnel to administer the above-named medication/treatment to my child.
- I understand it is my responsibility to furnish medication in the original container or prescription bottle. The container/bottle must be appropriately labeled by the pharmacy or HCP, stating name of medication, dosage, and instructions.
- I understand that only age/weight appropriate dosing of over-the-counter medications will be given unless accompanied by written authorization from a HCP.
- I understand it is my responsibility to monitor the action and side effects of the medication and ask that I be notified if the following occur:
  ______________________________________________________________________

☐ I give permission for my child to bring his/her medication(s) home at the end of the school year.

Parent/Guardian Signature: ___________________________________________________________

Date: ___________________________ Phone Number:______________________________

# Medication Administration Log

Student______________________________________________ DOB______________ Age_________ Grade_____________ School year__2024-2025_____

Medication_____________________________________ Dose________________________ Route_____________________________ Time___________________

| | Aug. | Sept. | Oct. | Nov. | Dec. | Jan. | Feb | Mar. | Apr. | May |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | - | - | 1 | 1 | - | - | - | - | 1 | 1 |
| 2 | - | - | 2 | - | 2 | - | - | - | 2 | 2 |
| 3 | - | 3 | 3 | - | 3 | - | 3 | 3 | 3 | - |
| 4 | - | 4 | - | 4 | 4 | - | 4 | 4 | 4 | - |
| 5 | - | 5 | - | 5 | 5 | - | 5 | 5 | - | 5 |
| 6 | - | 6 | - | 6 | 6 | - | - | 6 | - | 6 |
| 7 | - | - | 7 | 7 | - | 7 | - | - | 7 | 7 |
| 8 | - | - | 8 | 8 | - | 8 | - | - | 8 | 8 |
| 9 | - | 9 | 9 | - | 9 | 9 | - | - | 9 | 9 |
| 10 | - | 10 | 10 | - | 10 | 10 | 10 | - | 10 | - |
| 11 | - | 11 | 11 | 11 | 11 | - | 11 | - | 11 | - |
| 12 | - | 12 | - | 12 | 12 | - | 12 | - | - | 12 |
| 13 | - | - | - | 13 | 13 | 13 | 13 | - | - | 13 |
| 14 | - | - | 14 | 14 | - | 14 | 14 | - | 14 | 14 |
| 15 | 15 | - | 15 | 15 | - | 15 | - | - | 15 | 15 |
| 16 | 16 | 16 | 16 | - | 16 | 16 | - | - | 16 | 16 |
| 17 | - | 17 | - | - | 17 | 17 | 17 | 17 | - | - |
| 18 | - | 18 | - | 18 | 18 | - | 18 | 18 | - | - |
| 19 | 19 | 19 | - | 19 | 19 | - | 19 | 19 | - | 19 |
| 20 | 20 | 20 | - | 20 | 20 | 20 | 20 | 20 | - | 20 |
| 21 | 21 | - | 21 | 21 | - | 21 | 21 | 21 | - | 21 |
| 22 | 22 | - | 22 | 22 | - | 22 | - | - | - | - |
| 23 | 23 | 23 | 23 | - | - | 23 | - | - | 23 | - |
| 24 | - | 24 | 24 | - | - | 24 | 24 | 24 | 24 | - |
| 25 | - | 25 | 25 | - | - | - | 25 | 25 | 25 | - |
| 26 | 26 | 26 | - | - | - | - | 26 | 26 | - | - |
| 27 | 27 | 27 | - | - | - | 27 | 27 | 27 | - | - |
| 28 | 28 | - | 28 | - | - | 28 | 28 | 28 | 28 | - |
| 29 | 29 | - | 29 | - | - | 29 | - | - | 29 | - |
| 30 | 30 | 30 | 30 | - | - | 30 | - | - | 30 | - |
| 31 | - | - | 31 | - | - | 31 | - | 31 | - | - |

**NOTE TIME AND INITIALS BY DATE MEDICATION ADMINISTERED.**

Initials Signature

Initials Signature

Initials Signature

| Key |
|---|
| NSD: No School Day |
| N: No medication available |
| W: Weekend |
| A: Absent |
| R: refused |
| F: Field trip |
| SN: See note |

Notes: