~St. John the Baptist School~
~Where small can make a BIG Difference~
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Parent and Physician's Authorization for Administration of Medication in School & School Activities

A. To be completed by parent or legal guardian:

I request that my child _____ DOB _____ be assisted in taking the medication described below by authorized persons or be permitted to carry and self-administor to him/herself as authorized by physician.

Signature (Parent or Guardian):_____ Date: _____

Phone #:_____ (home/cell) **Work Phone #:**_____

*Medication must be in the original pharmacy labeled container with specific orders and name of medication, or in the case of over the counter medication, in the original, unopened package.
*Medication and refills must be brought to school by a parent, guardian or responsible adult.

B. To be completed by Physician:

I request that my patient, as listed below, receive the following medication:

Name of Student:_____ DOB_____

Diagnosis:_____

Medication	Dosage	Frequency/Time	Route of Administration

I deem this child capable to carry and self-administer medication (yes or no)_____

Possible side effects and adverse reactions (if any):

Date:_____

Physician's Signature:_____

Physician's Name Print:_____

Address:_____

Phone:_____

This medication order is valid for the current 26/27 School Year and Summer School as needed