Brother Rice High School

"Act Manfully in Christ Jesus"

SCHOOL YEAR: _____

Graduation Class: _____

MEDICATION AUTHORIZATION

NAME: _____ I.D. NUMBER _____ DATE _____

MEDICATION(S) _____

DOSAGE _____

TIME OF ADMINISTRATION _____

DIAGNOSIS REQUIRING MEDICATION _____

POSSIBLE SIDE EFFECTS _____

OTHER MEDICATIONS STUDENT IS RECEIVING _____

PHYSICIAN'S SIGNATURE _____

PHYSICIAN'S NAME PRINTED _____

PHYSICIAN'S PHONE NUMBER _____

I certify that the above-named student has been instructed in the use and self-administration of

_____
(Name of Medication)

PARENT/GUARDIAN AUTHORIZATION:

I hereby authorize the administration of the above medication (or in the case of an inhaler, the self-administration) during school hours, under the supervision of the School Nurse at BROTHER RICE HIGH SCHOOL. I will notify the School Nurse of any changes in medication or my child's condition.

PARENT/GUARDIAN SIGNATURE _____

( ) _____ or ( ) _____

Home Phone Work Phone