CALVARY
EPISCOPAL PREPARATORY

Parent-Physician Authorization for Medication Administration

Student's Name_____ **Date of Birth**_____ **Allergies**_____

Medication_____ **Strength**_____ **Dose**_____

☐ **Scheduled**: every _____hours **OR** at scheduled time(s)_____

☐ **As needed**: every _____hours **OR** _____ times a day

Start date_____ **End date**_____(Valid for current school year only)

Reason for medication_____

Possible reactions or restrictions_____

NOTE:

- Over-the-counter medications must be furnished by the parent/guardian and given to the school nurse *in the original container.*
- Prescription medications must be in the original container *with the original pharmacy label intact*. If needed, a second container can be obtained from your pharmacist so only the appropriate amount of medication is delivered to school.
- If a medication is a controlled substance or needs to be given at school for more than six weeks, a physician's signature is required.
- A physician's order is required if a student must keep a medication (EpiPen®, inhalers, etc.) with him/her while at school. The medication must be in the original container with the original pharmacy label.

I agree to the above and give permission for the medication listed to be given by Calvary Episcopal Preparatory personnel during school hours.

Parent/Guardian Signature_____ **Date**_____

THE SECTION BELOW IS TO BE COMPLETED BY A PHYSICIAN (IF REQUIRED).

Instructions/Comments_____

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Physician's Signature_____ **Date**_____

Physician's Printed Name_____ **Phone #**_____