



# SAINT PATRICK SCHOOL

Embracing the **Spirit** of Education

## 2010-2011 School Year Medication Administration Form

Child's Name: \_\_\_\_\_

Please indicate, in detail, all allergies or mark no known allergies:

My child has the following allergies:

Food: \_\_\_\_\_

Environment: \_\_\_\_\_

Medication: \_\_\_\_\_

Other: \_\_\_\_\_

My child has no known allergies.

**I authorize the school nurse or her designee to use his/her discretion in giving the following medication to my child:**

- Acetaminophen (generic Tylenol)
- Antihistamine (generic Benadryl -6 years old and older unless prescribed by physician)
- Antacid (generic Tums)
- Ibuprofen (generic Motrin)

**I DO NOT authorize the school nurse or her designee to use his/her discretion in giving the above medications to my child.**

\_\_\_\_\_  
(signature of parent)

\_\_\_\_\_  
(date)

**Additional Medications to be administered at school:** Medications must be in the original container with student's name, name of the medication, directions for administration, date and health care provider's name and signature. The signature can be on a separate note (such as a prescription) but it must accompany the medication and include the child's name, date and medication on it. Medications will be locked in the nurse's office and will be administered as prescribed.

Name of Medication	Dosage and Route	Time/Frequency
_____	_____	_____
_____	_____	_____

\_\_\_\_\_  
(signature of parent)

\_\_\_\_\_  
(date)