AUTHORIZATION FOR MEDICATION ADMINISTRATION

St. John School * 1003 Encinitas Blvd., Encinitas, CA 92024 | **School Year :**

I, the undersigned, as legal parent/guardian of : _____________________________ / __________________ / _____ / ________ ,
Student Name Teacher Grade DOB
request that the below listed medication(s) be made available to my child as indicated.

I understand that personnel authorized by the school will assist my child in taking the medication as directed by my physician. I authorize school personnel to contact my physician as needed.

I agree to follow the medication administration policy as outlined in the St. John School Parent Handbook.

I understand that if any of the conditions in the Provider Statement change, a new form must be signed by the parent/ guardian and the provider.

I agree to hold St. John School, its officers, employees or agents, harmless from all liability suits or claims, of whatever nature or kind, which might arise as a result of administering the medication in accord with this request.

Parent/Guardian Signature: ____ Date: ____________________

____
Home address City Zip

_(____)______________________ _(____)______________________ _(____)______________________
Home phone Cell phone Work phone

Prescription and non-prescription medications are not permitted to be taken at school without a written statement from a California-licensed physician and a written statement from the parent/guardian indicating desire that St. John School assist the student as set forth in the Provider Statement below.

Provider Statement

This portion to be completed by a physician, dentist, nurse practitioner, or physician assistant licensed in the State of California.

	Name of Medicine	**Method of Administration**	**Dosage**	**Approx. Time of Day** if PRN, describe symptoms
1.				
2.				

Diagnosis/Reason for Medication

Precautions/side effects for administration or storage of medication:

______________________________ ____________________ _(____)______________________
Printed name of Provider License No. Phone Number

Provider Signature: ______________________________ Date: ____________________________