ST. MARGARET MARY
CATHOLIC SCHOOL

AUTHORIZATION TO ADMINISTER MEDICINE AND/OR SHARE KNOWLEDGE OF ALLERGIES

(One form per student)

Student's Name: _____

Grade: _____ School Year: _____

Date of Birth: _____

Physician's Name: _____ Phone: _____

Whenever possible, the parent/guardian should make arrangements for medication to be administered at home, before or after school hours. Saint Margaret Mary School does not employee a nurse. This form gives permission for the office staff or school principal's designee to administer medication as prescribed by a licensed doctor. ***A PHYSICIAN'S ORDER/PRESCRIPTION MUST BE ATTACHED.*** Whenever possible, students will self-administer medication under the supervision of the above named staff. Students are allowed to carry and administer rescue inhalers and Epinephrine Auto-Injectors if necessary. We would ask that you let the school know if your child will be carrying one of these items.

1. Name of Medication:_____

Specific dose: _____ Reason for Medication: _____

2. Name of Medication:_____

Specific dose: _____ Reason for Medication: _____

3. Name of Medication:_____

Specific dose: _____ Reason for Medication: _____

I hereby authorize St. Margaret Mary Catholic School to administer the above medication(s) to my child.

_____ _____

Parent/Guardian Signature **Date**

The next two statements pertain to students with allergies and NEED ONLY BE SIGNED BY A PARENT OF STUDENT WITH ALLERGIES.

- I consent to my child's name being included on an allergy list provided to teachers/volunteers for the express purpose of making them aware of students who might have an allergic reaction while in their supervision. ***Circle one:*** ☐ ***YES*** ☐ ***NO***

Allergies: _____

AND/OR

- My child will need to carry the following medication with him/her at all times.
- Please circle the proper medicine if this statement applies to your child.

Circle all that apply: ☐ ***Rescue inhaler*** ☐ ***Epinephrine Auto-Injector (Epi-pen)***

_____ _____

Parent/Guardian Signature **Date**