**ANNUNCIATION CATHOLIC ACADEMY**
**AUTHORIZATION FOR ADMINISTERING STUDENT MEDICATION**

DATE:____________________________

My permission is hereby granted to_________________________________________
(SCHOOL)
to administer prescribed medication to_______________________________________
(STUDENT'S FULL NAME)

Name of Medication_____________________________________________________

Amount to be given_____________________________________________________

Time(s) to be given_____________________________________________________

Date to begin_________________________ Stop Date______________________

Name of Pharmacy______________________________________________________

ALLERGIES: ☐ No Known Allergies ☐ ________________________

It is necessary that this prescribed medication be provided during the school day, (including when the student is away from school property on official school business)
because:__________________________________________________________

__________________________________________________________________

SIGNED:__________________________________________
(Signature of Physician)

and

SIGNED:__________________________________________
(Signature of Parent/Guardian)

NOTE: (1) All prescribed medication to be administered at school must be received in **original containers**.

(2) All prescribed medication to be administered at school to a student must be delivered to and retrieved from the school by the student's parent, legal guardian, or another adult who presents written authorization from the student's parent or legal guardian.