ST. FRANCIS OF ASSISI ELEMENTARY MEDICATION PERMISSION

Student Name:_____Date of Birth:_____
Parent/Guardian Names:_____Parent/Guardian Phone Numbers:_____
Physician:_____Physician Phone number:_____

If you are sending prescription medication or non-prescription medication for your child then you *must: 1. Indicate the type of medication(s) etc below; 2. Sign where indicated; and 3. Obtain your doctor's signature. IMPORTANT:* You must ensure that all medications are FDA approved for use in this manner, properly labelled, and *in their original containers.* For students to be given the medications BOTH parent AND physician signatures are REQUIRED at the bottom of this form.

SECTION 1: NON-PRESCRIPTION (OVER-THE-COUNTER) MEDICATION

Over-the-counter medication will NOT be administered without parent AND physician signatures. The above named student is approved to take the following medications, as needed, in accordance with the directions on the packaging. Please check "yes" or "No".

STUDENT AGE: _____ **STUDENT WEIGHT:** _____

Medication	As Needed for	Yes	No	Medication	As Needed for	Yes	No
Ibuprofen (Motrin/Advil)	Pain or Fever			Cough Drop/Throat Lozenge	Cough or sore throat		
Acetaminophen (Tylenol)	Pain or Fever			Antacid	Upset Stomach		
Diphenhydramine (Benadryl)	Allergic Reaction/ Rash			Vaseline (Topical)	Dry Lips		
Anti-itch Lotion	Itchy skin/bug bites			Other:_____			
Eye drops	Allergies/irritation			Other:_____			

Comments:_____

Please list any allergies (medication, food) or concerns:

_____

_____

SECTION 2: PRESCRIPTION MEDICATION

Medication Name	Condition Prescribed for	Possible Side Effects	Dose	Method (e.g. by mouth etc)	Time(s)	Frequency

SECTION 3: PARENTAL CONSENT AND AUTHORIZATION

I, the undersigned, the parent/guardian of the above named student, request my student be assisted with or administered the medication listed above according to California and Diocesan regulations. I will:

1. Provide all prescription medications, supplies and equipment.
2. Notify the school if there is a change in the student's health status or attending physician.
3. Notify the school immediately and provide a new consent for any changes in the doctor's orders.

I authorize the school to communicate with the Authorized Health Care provider if necessary in regards to the above medication/ medical condition. I hereby authorize an unlicensed designated school personnel to administer or assist in the administration of the above prescription medications and/or over-the counter medications (as needed).

PARENT/GUARDIAN SIGNATURE:_____ **DATE:** _____

SECTION 5: PHYSICIAN CONSENT AND AUTHORIZATION

My signature below provides the authorization for the above written orders. I understand that all procedures will be implemented in accordance to CA state laws and regulations and Diocesan regulations. I understand that an unlicensed designated school personnel may administer or assist in the administration of the above medication(s). This authorization is valid for one year. If changes are indicated, I will provide new written authorization (may be faxed).

PHYSICIAN SIGNATURE:_____ **DATE:** _____ **STAMP:**