Blessed Sacrament School
Medication Administration Consent Form

AUTHORIZATION FOR MEDICATION: Over-the-Counter Medicines

Student's Name: ______________________Date of Birth: _______________Grade: _____________

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Allergies: ____
Diagnosis: ____

MEDICATION	DOSAGE & ROUTE	FREQUENCY	SPECIFIC TIMES	SPECIAL INSTRUCTIONS/ SIDE EFFECTS

PARENTAL PERMISSION FOR MEDICATION

(TO BE COMPLETED BY THE STUDENT'S PARENT / GUARDIAN)

I grant the school nurse or his / her designee the permission to assist or perform the administration of each medication to or for my child during the school day, including when he/she is away from school property for official school events. If my child has been authorized by his/her physician to self-administer their medication(s), I grant permission for my child to self-administer their medication at school and when they are away from school property for official school events. In the event that my child is unable to self-administer their medication, I give permission for the nurse/designee to perform the administration of the prescribed medication.

NOTE:

- **Medications must be supplied in the original container.**
- School personnel may administer only over-the-counter medications authorized by a parent/physician.
- It is your responsibility to notify the school when there is a change in medication regimen.

_______________________________________ Parent / Guardian Name (Printed)

_______________________________________ Signature of Parent / Guardian

_______________________________________ Date Signed

_______________________________________ Home Phone Number

_______________________________________ Work/Cell Phone Number (Include Ext. if any)