OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON
MEDICATION AUTHORIZATION

NOT FOR EPINEPHERINE OR INHALER AUTHORIZATION

Release and indemnification agreement

PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE

PART I TO BE COMPLETED BY PARENT OR GUARDIAN

I hereby request designated school personnel to administer medication as directed by this authorization. I agree to release, indemnify, and hold harmless the designated school personnel, or agents from lawsuits, claim expense, demand or action, etc., against them for helping this student use medication, provided the designated school personnel comply with the Licensed Healthcare Provider (LHCP) or parent or guardian orders set forth in accordance with the provision of part II below. I have read the procedures outlined on the back of this form and assume responsibility as required

Medication ☐ Renewal ☐ New (If new, the first full dose must be given at home to assure that the student does not have a negative reaction.)

First dose was given: Date____________ Time____________

Student Name (Last, First, Middle)	Date of Birth

Allergies	School	School Year

No LPN or clinic room aide shall administer medication or treatment, unless the principal has reviewed all the required clearances.

______________________ ______________________ ______________

Parent or Guardian Signature | Daytime Telephone | Date

PART II TO BE COMPLETED BY PARENT OR GUARDIAN FOR OCCASIONAL OVER THE COUNTER (OTC) MEDICATION. LICENSED HEALTH CARE PROVIDER (LHCP) MUST COMPLETE AND SIGN FOR ALL OTHER MEDICATIONS AND OTC'S ADMINISTERED FOR 4 OR MORE DAYS.

The school discourages the use of medication by students in school during the school day. Any necessary medication that possibly can be taken before or after school should be so prescribed. Injectable medications are not administered in schools except in specific situations with appropriate forms that comply with LHCP orders and are signed by parent or guardian. School personnel will, when it is absolutely necessary, administer medication during the school day and while participating in outdoor education programs and school crisis situations according to the procedures outlined on the back of the form. Information should be written in lay language with no abbreviations.

DIAGNOSIS:	SIGNS / SYMPTOMS:
MEDICATION:	ROUTE:
DOSAGE TO BE GIVEN AT SCHOOL:	TIMES OR INTERVAL TO BE GIVEN:
EFFECTIVE DATE: Start: End:	If the student is taking more than one medication at school, list sequence in which medications are to be taken

COMMON SIDE EFFECTS:

______________________ ______________________ ______________ ______________

Licensed Health Care Provider (Print or Type) | Licensed Health Care Provider (Signature) | Telephone and Fax | Date

______________________ ______________________ ______________ ______________

Parent or Guardian Name (Print or Type) | Parent or Guardian (Signature) | Telephone | Date

PART III TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE

Check ✓ as appropriate:

☐ Parts I and II above are completed including signatures. (It is acceptable if all items in part II are written on the LHCP stationery or a prescription pad.)

☐ Medication is appropriately labeled. ______________ Date by which any unused medication is to be collected by the parent (Within one week after expiration of the physician order or on the last day of school).

______________________ ______________________

Signature | Date