TRINITY
PREPARATORY SCHOOL

AUTHORIZATION FOR ADMINISTERING STUDENT MEDICATIONS

Date: _____

I am requesting Trinity Preparatory School administer a prescribed or necessary over-the-counter medication to: (please print all answers)

Student's name: _____ Grade: _____

Medication name & dosage strength:_____ _____

Amount to be given (number of tablets or ml): _____

Time to be given:(specific time or "as needed") _____

Date to begin: december _____ Date to end: _____

Special instructions ***or*** side effects that could impact student at school: (take with food, take before meal, use inhaler when coughing or wheezing, may cause drowsiness, may cause stomach ache)

_____

Reason medication is needed during school hours:

- ☐ Physician ordered during this time frame
- ☐ Medication is needed at lunchtime
- ☐ Parent/guardian deems spacing medication during the day requires this timeframe
- ☐ This is an "as needed" medication

NOTE:

1) All prescription medications must be current, hand-delivered to the school clinic by the parent/responsible adult, and received in the **ORIGINAL** container with the prescription label intact showing the student's name and medication information.
2) No medication can be given without a signed authorization form.
3) **It is the student's responsibility to go to the nurse to receive their medication.**
4) All medications must be picked up at the end of the school year, or they will be destroyed & discarded after the last day of school.

_____ _____

Parent/Guardian Signature Date