

SMS Medication Administration Permission and Record Sheet

(one form per child per medication)

Student's Name _____ Age/Grade _____ Today's Date _____

Starting Date _____ Stopping Date _____

Name of Medication _____

Reason for Administration _____

Is this Medication: (circle one) Over the Counter OR Prescription

*****prescription medicine needs to be in the original bottle dispensed by the pharmacy with the instructions for administration on the bottle.***

*****over the counter medicines must be in the original containers & dose appropriate.***

Dosage _____ Time Medication to be Given _____

Route: Oral _____ Nasal ___ left, right, both _____ Eye Drops ___ left, right, both

Topical _____ location to be applied _____ Inhaled _____

Injection _____ location to be administered _____

Should Medication be Taken with Food: (circle one) Yes No Other Specific

Instructions _____

Any Previously Known

Side-Effects _____

As the parent/guardian of this child I give my permission for the school staff of St. Monica School to administer the above medication per the above instructions. I also acknowledge that I have provided the school with the above medications in accordance with the Archdiocese policy. This can be updated every year via parent initials.

Parent/Guardian Signature _____