

## **AUTHORIZATION FOR MEDICATION**

Name of Student:		Grade:
School:		
Phone Number:	Fax Number:	Date:
MEDICATION TRE	EATMENT PLAN TO BE COMPLETE	ED BY PHYSICIAN
Diagnosis:		
Medication, Dosage, Specific medication, dosage, frequency	Time and Direction for Administration y and time separately):	n (Please write each
	ipplied in the original prescription col completely labeled containers, provi	
Side Effects/Special Instruction	ns:	
students who require any spec	se complete the treatment plan on the cial health procedures during school stioning, tube feedings, glucose testing	hours, (ie:inhalers,nebulizer
Printed Name or Stamp Physic	cian:	
Physician's Phone Number:		
Physicia's Fax Number:		
PARENTAL PERMI	SSION TO BE COMPLETED BY PA	ARENT/GUARDIAN
medication/procedure to be pr	ee the permission to assist in the adrovided during the school day, including the school propert	ing when
Signature of Parent:		
Home /Cell Phone Number:		
Work Phone Number:		

## Treatment Plan: Special Procedures (List special procedures in which students have been trained (ie: insulin administration, use of Epi-Pen, nebulizer, testing glucose levels, etc.): Please list any limitations that should be considered (ie: physical education, outdoor activities, etc.) Please state the emergency precaution that should be considered (ie:allergy triggers, diabetes reaction, etc.)

Our Mission Statement: Saint Jerome Catholic School is a Eucharistic family that empowers students to grow in knowledge, love, and respect. Inspired by the Gospel, we engage our parish and school community in joyful service.

Physician's Signature:\_\_\_\_\_ Date: \_\_\_\_\_