

**ST. ALPHONSUS SCHOOL  
AUTHORIZATION FOR THE ADMINISTRATION  
OF MEDICATION**



Please note:

- A) The parent/guardian is required to provide a copy of the prescription or medication label prior to the administration of the medication.
- B) The school principal or his/her designate is to administer the medication.
- C) The parent/guardian is responsible for the delivery and supply of the medication.

Student's name: \_\_\_\_\_ Grade: \_\_\_\_\_

Name of Medication(s):  
\_\_\_\_\_

Dosage, method and time(s) of administration:  
\_\_\_\_\_  
\_\_\_\_\_

Length of time medication will need to be taken:  
\_\_\_\_\_

Specific storage requirements (if any):  
\_\_\_\_\_

Is medication to be sent home at the end of the day?    \_\_\_ Yes    \_\_\_ No

Other relevant information (if any):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby request and authorize that the above-named medication be administered to my child at school.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent/guardian