



HOLY SPIRIT

PREPARATORY SCHOOL

Authorization to Give Medication at School 2021-22

If medications can be given at home or after school hours, please do so. However, if medication must be given during school hours, this form must be completed.

| | | |
|---|------------|-----------------------------------|
| STUDENT NAME | | |
| TEACHER | | GRADE |
| <p>I hereby request that Holy Spirit Preparatory School, through its designated authority, supervise/assist in the administering of medication to my child, according to the instructions contained on the statement below. I understand that:</p> <ul style="list-style-type: none"> • Medications must be in the original labeled container (no baggies, foil, etc.) • Parent /guardian must provide specific instructions, as well as the medication and related equipment to the principal, or clinic personnel. • It will be the responsibility of the parent / guardian to inform the school of any changes. New medication or new doses will not be given unless a new form is completed. • All medication will be taken directly to the office / clinic by the parent. • Medications must be picked up at the end of the year, or will be disposed of by the school. | | |
| NAME OF MEDICINE | | DOSAGE AND TIME OF ADMINISTRATION |
| STOP MEDICATION ON (ENTER DATE) | | CHILD'S MEDICATION ALLERGIES |
| PHYSICIAN'S NAME | | PHYSICIAN'S PHONE |
| I release the school board, the school, and any school employee from any liability for administering this medication. | | |
| PARENT/GUARDIAN SIGNATURE | | DATE |
| HOME PHONE | CELL PHONE | WORK PHONE |

To be completed by Health Care Provider for long term medications (more than two weeks):

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|-----------------------------------|-------------------------------|
| CONDITION REQUIRING MEDICATION | POSSIBLE SIDE EFFECTS, IF ANY |
| SIGNATURE OF HEALTH CARE PROVIDER | DATE |