Powers Catholic High School

2024-2025 Medication Administration Permission Form

Student's Name: ____**Grade:** __________

ALLERGIES: ____

Date form received by school: ________________________________ **Date of Birth:** _______________

Name of Medication: ____

Reason for Medication: ____

Form of Medication/Treatment: (circle) Tablet Liquid Inhaler Injection Nebulizer Other

Instructions: **Dose & time** to be given at school: ____

____

Start Date: **(Or)** Date form received ____

Stop Date: End of School Year (**or** Other date): ____

Restrictions and/or important side effect(s): ____

Special Storage Requirements: (refrigerate, etc.) ____

The student is both capable and responsible for *self-administering* this medication:

No ***Yes*** (Supervised) ***Yes*** (Unsupervised)

Student *may carry* this medication: (circle) ***Yes*** ***No***

CONTROLLED SUBSTANCES, SCHEDULE I-V, CANNOT BE HELD/CARRIED BY THE STUDENT

Physician's Signature: __________________________________ **Date:** __________________________
Physician's Name: ____
Physician's Address: ____
Physician's Phone Number: ____

To be completed by the parent/guardian:
I give permission for the above medication to be given by a designated Powers Catholic employee.

Signature: ____ **Date:** ______________________

Relationship: ____ **Phone:** _____________________

*Includes prescription & over-the-counter medications, i.e. acetaminophen, Benadryl, Claritin, cough drops, ibuprofen, Neosporin, etc. **A valid and current dated form must be submitted each school year.**