OUR LADY'S ACADEMY

Authorization to Administer Prescription (Rx) Medication in School

Accredited by the NEAS&C

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Nurse's Tel: 781-899-5027

Parent/Guardian Permission for the following student:

_____ _____ _____
Student's Name Grade Date of Birth

1. I give permission to the school nurse to give the following Rx medication _____
   prescribed by _____
   to the student listed above.
2. I give permission to the school nurse to share medical information with my child's healthcare provider regarding the prescribed medication: □ Yes □ No
3. List any restrictions on the release of information by the school nurse: _____
   _____
4. My child is receiving the following medication(s): (a) _____
   (b) _____ (c) _____

_____ _____
Signature of Parent/Guardian Date

Physician/Licensed Prescriber:

I request that my patient _____
receive the following medication:

Medication: _____
Dosage and Route of Administration: _____
Time to be given during school hours: _____
Duration: _____
Parameters: _____

_____ _____
Signature and Stamp of Physician/Licensed Provider Date

_____
Provider's Phone Number