St. Jude the Apostle School
9150 Highland Road
Baton Rouge, Louisiana 70810
(225) 769-2344, fax: (225) 769-0671

Medication Administration
Parent/Physician Authorization

Date: ________________________________

I request that my child, _____________________________________ in grade ____________
be given medication during school hours as ordered below by the physician.

I accept the rules of the school/diocese concerning the administration of medicine, including the following:

1. The medication must be prescribed by a physician who advises the school that it is NECESSARY for the child to be given the medicine at school. The physician's signature is required below, or on a separate note attached to this form.

2. The medication will be provided to the school by an adult in the original container, which indicates the child's name, physician's name, medication name, dosage and time to be given. The empty container will be sent home with the child.

3. The school or designated person administering the medication is not responsible for any unintentional mistake or oversight in keeping or giving the child's medication.

____
Parent or guardian signature

PHYSICIAN'S ORDER

It is necessary for the medication listed below to be given during school hours.

MEDICATION: ____

DOSAGE: ____

TIME TO BE GIVEN: ____

DURATION OF ADMINISTRATION: _________________________________

____
Physician's signature

____
Telephone number