

Holy Family School System

**PERMISSION FOR
PRESCRIPTION & NON PRESCRIPTION MEDICATION**

I hereby authorize the school nurse or delegated personnel at Holy Family Schools to administer the following medication;

Student's Name _____

Medication (Name)_____ Strength_____

Dosage to be given each time: _____

At what hour is the dosage given at home?_____

At what hour is the dosage to be given at school?_____

The above medication is to be given until:_____

Health condition for which medication must be given at school:

We must have the original medicine or prescription bottle with the medicine in it. Prescription containers must include the following information: name of medication, dosage, time to be given, name of doctor, name of student, and route of administration.

Signature_____

(Parent/Guardian)

Date _____