DIOCESE OF ST. AUGUSTINE

REQUIRED CLINIC FORMS

ST·JOSEPH
CATHOLIC SCHOOL

OVER THE COUNTER MEDICATIONS

(Ex: Cough drops, Ibuprofen, Pepto-Bismol, Tylenol, etc.)

- [ ] Medical Authorization **One form for each medication*

PRESCRIPTION MEDICATIONS

- [ ] Medical Authorization **One form for each medication*

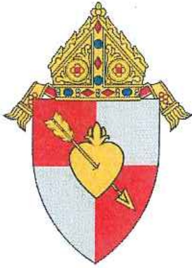
INHALER

- [ ] Physician's Order for Self-Administration of Student
- [ ] Parental Authorization for Student to Self-Medicate

STUDENTS REQUIRING EPINEPHRINE

- [ ] Medical Authorization **One form for each medication*
- [ ] Authorization for Administering Medical Treatment (3 page treatment plan)
- [ ] Epinephrine Liability Waiver

www.stjosephcs.org/forms



Medical Authorization

The following section is to be completed by the **PARENT/GUARDIAN** for the administration of medication. Medications must be in original containers.

Child's Name:______________________________ ________ ____________
Last First Sex Date of Birth

____ (____) ____________
Physician's Name Address Telephone

I deliver the medicine(s) described below to ***St. Joseph Catholic School*** *to be held for use by my child in accordance with the instructions given below. I consent and authorize the person designated by the School to dispense and to supervise my child's self-administering the medicine(s). We/I understand that the School assumes no responsibility for the instructions we/I have provided below, other than to allow my child to self-administer the medicine(s) and we/I assume all risk associated with the child's taking such medicine(s).*

We/I understand that under the provision of Florida Statute 232.46, school personnel cannot be held liable for reactions or side effects from the administration of the medication(s). We/I also grant permission for school personnel to contact the physician if there are questions or concerns about the medication(s).

______________________________ (____)____________ (____)____________
Date ***PARENT/GUARDIAN*** Signature Home Phone Emergency Phone

The following is to be completed by the **PHYSICIAN**:

Diagnosis for which medication is given: ______________________________

Name of Medicine______________________________

Form ______________________________

Dose ______________________________

If medicine is to be given DAILY, at what time? ______________________________

If medicine to be given "WHEN NEEDED," describe indications: ______________________________

____

How soon can it be repeated?______________________________

Is child authorized to medicate herself/himself?______________________________

List significant side effects: ______________________________

Length of time this treatment is recommended: ______________________________

Other information: ______________________________

______________________________ ______________________________
Date Physician Signature