

SAINT ANTHONY PARISH SCHOOL
KAILUA

AUTHORIZATION TO ADMINISTER MEDICATION

We, _____, the parents of
_____, authorize St. Anthony

Parish School to administer the following:

<u>Name of Medication:</u>	<u>Dose:</u>	<u>Time:</u>	<u>Reason for Medication:</u>
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Possible side effects to watch for with (medication). _____

Name and phone number of prescribing physician:

The medication container must have:

- ___ original prescription label.
- ___ name of child on the container.
- ___ name of physician.
- ___ dated label (including expiration date).

Additional instructions for administering: _____

Parent Signature:

Date:

The medication container must have: