



Catholic Schools - Diocese of Salt Lake City

PARENT REQUEST TO ADMINISTER MEDICATION

I hereby authorize _____ to administer the
(name of school)

medication described below to my child, _____ in grade _____
(name of child)

Name of Medication: _____

Dose of Medication to be given: _____

Time to administer medication: _____

Dates to be given: Begin on ___/___/___ End on ___/___/___

The child is receiving medication for treatment of

Possible side effects _____

Physician name

Phone #

Date

I understand that the office staff or school nurse will administer only the medication described above. I also understand that no medication will be given without a release and that each medication must have a release. If a new medication or dose change is implemented a new release must be completed.

Parent signature

Day time phone #

Date

Director of School Health

Date