



Marian Central Catholic High School 2019-2020  
Medication Authorization Form

It is our policy that (Rx) prescription and (OTC) over-the-counter medication should be administered in the home when at all possible. However, under certain circumstances, it is in the best interest of the student to take prescribed or OTC medication during the school day. In the case of the student needing a prescription medication during the school day, the doctor and the parent/guardian must provide authorization to the school office. In the case of the student needing an over-the-counter medication during the school day, the parent/guardian must provide authorization to the school office. The medication must be brought to the school office in the original container that includes all prescription or OTC information including the student's name. The parent/guardian must assume responsibility for informing the school in writing of any change in the student's health or change in medication. The prescribed or OTC medication will be kept in the school office, and the student is responsible for coming to the school office to take the medication. A Medication Log will be kept in the office where each student must sign every time a medication stored in the office is taken. A student may carry on his or her person and may self-administer an epinephrine auto-injector or asthma inhaler where the student or student's parent/guardian supplied the epi-pen or asthma inhaler, and presented the school with a prescription authorizing the student to use the epi pen or inhaler. A parent whose child's condition requires the use of an epi-pen or asthma inhaler is required to notify the school, provide a prescription for the epi-pen, supply the prescribed pen or asthma inhaler to the student, and complete the forms required by the school. The prescription may be written by a physician, a physician assistant, or advanced practice nurse. This Authorization is valid for the dates indicated or the end of the current school year.

Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

**Over the Counter Medication Authorization**

Medication: \_\_\_\_\_

Dose: \_\_\_\_\_ Time of Administration at School: \_\_\_\_\_

I hereby state that the information is above is accurate and give permission to Marian Central Catholic High School personnel to administer the medication identified to the above-named student.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Prescription Medication Authorization**

Medication: \_\_\_\_\_

Dose: \_\_\_\_\_ Time of Administration at School: \_\_\_\_\_

Duration (from date): \_\_\_\_\_ to (date): \_\_\_\_\_

Reason for medication prescribed: \_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_