ST. VINCENT DE PAUL CATHOLIC SCHOOL
PARENT AUTHORIZATION TO DISPENSE MEDICATION

NAME_____ **BIRTH DATE**_____

PARENT/GUARDIAN_____

HOME PHONE_____ **WORK PHONE**_____ **OTHER**_____

GRADE_____ **TEACHER**_____

I request that the following medication be administered to my child by the appropriate school staff member.

Name of medication_____

Prescribed by _____ _____
(Physician's Name, if prescribed medication) (Telephone Number)

Amount to be given_____

Time of day to be given_____

Expected Duration of administering medication: From _____ Through _____

Comments:

1. Possible side effects _____

2. Other helpful information concerning medication _____

I understand that this medication will be furnished by me, given to a school staff member and provided in the original container. I will notify the school immediately if the medication has been discontinued or dosage changed. I give consent for a St. Vincent de Paul School staff member to contact my child's physician's office for clarification of this prescription order.

_____ _____
(Signature of Parent/Guardian (Date)

***Additional Notes: Any medication on hand at the end of the school year will be disposed of if not picked up by parent.**

A new permission letter is required each school year for each medication to be given.