Authorization for Administration of Oral Medication

Student's Name______________________________________ Birth Date ___________________

Name of Medication	Dosage	Methods of Administration	Time of Day to be Taken

Reasons for medication to be given during program/retreat hours _________________________

Anticipated action ____

Possible side effect of medication____

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Emergency procedure in case of serious side effect ____

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize a designated parish staff person to administer the above identified medication to the above identified student in accordance with the prescription or doctor's instructions for the period beginning __________________(date) through ________________(date).

Medication will be supplied to the parish staff person in the original container(s), bagged and labeled with the participant's name.

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Parent/Guardian Signature Date

Home Phone___________________________________Work Phone______________________________

Cell Pone______________________________________