Department of Catholic Schools
Archdiocese of San Antonio
2718 W. Woodlawn Ave
San Antonio, Texas 78228
Telephone: (210) 734-2620
www.sacatholicschools.org

MEDICATION PERMISSION REQUEST FORM

Please fax form to _____ **at fax number** _____ .
(School Name)

According to the policies of the Archdiocese of San Antonio, students are not allowed to carry any medication on their person. (An exception may be allowed if, by physician direction, a student requires diabetic or rescue medication.) The principal designates a responsible person to supervise the storing and administration of medications at school. Medication may be administered by non-medical personnel. The school will be held harmless for adverse drug reactions and side effects of properly administered medication. The following steps must be taken before a student is allowed to take medication at school:

1. The prescribing health care provider (*either a licensed Physician, Dentist, Physician Assistant or Nurse Practitioner*) must complete this form so that medication may be given by school personnel.
2. **Parent/guardian** must present this completed consent form to the school
3. **Parent/guardian** must bring the medication in the original prescription bottle, properly labeled by a registered pharmacist as prescribed by law. If bringing a prescribed over-the counter, must be accompanied by prescription and in original, unopened container labeled with the student's name.

Student Name: _____ Grade: _____

Date of Birth: _____ School: _____

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TO BE COMPLETED BY HEALTH CARE PROVIDER

Medication #1 _____
Name Strength Dose Route Time (at school)

Medication #2 _____
Name Strength Dose Route Time (at school)

Medication #3 _____
Name Strength Dose Route Time (at school)

Duration: _____

Allergies: _____

Special Instructions: _____

Printed Name of Health Care Provider (MD/DO/PA/NP/DSS/DMD): _____

Signature of Health Care Provider: _____ Date: _____

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TO BE COMPLETED BY PARENT

I, _____, request that my child be given the above medication as directed. The school and its employees will be held harmless for adverse drug reactions and side effects of properly administered medication.

Signature of Parent/Guardian: _____ Date: _____

Telephone: (Home) _____ (Work) _____ (Mobile)_____