St. Peter's Catholic School
34 Main Street, PO Box 357
Hokah, MN 55941
www.stpetershokah.org
(507) 894-4375

Medication Administration and Parent Authorization Form

Student information:

NAME: _____

BIRTHDATE: _____ GRADE: _____

MEDICATION: _____ DOSE: _____

ADMINISTRATION DATES: _____ TIME: _____

INDICATION TO ADMINISTER _____

(example: pain, headache, ADHD, infection, etc.)

PARENT CONSENT:

1. I request the above medication be given during school hours.
2. I will notify the school of any change in medication.
3. I release the school from any liability in relation to this request when the medication is given as ordered.
4. Medication will be supplied in its original and properly labeled container.
5. I give the school permission to communicate information to staff about the medication and/or side effects.

Parent Signature: _____

Date: _____ Phone number: _____

Physician Order:

* Only required for prescription medications. Order can be emailed to secretary@stpetershokah.org.

Physician Signature: _____

Date: _____ Phone number: _____

Date	Time	Initials	Date	Time	Initials

Initials: _____ Printed Signature: _____

Initials: _____ Printed Signature: _____

Initials: _____ Printed Signature: _____

Initials: _____ Printed Signature: _____