St. Columbkille School

224 E. 5th Street
Papillion, NE 68046
Phone: (402) 339-8706
FAX: (402) 592-4147

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION
2010-2011

All medication must be brought in the prescription container with the original pharmacy label. Prescriptions must be labeled with the student's name, date, name of medication, medication dose, and time to be given. Medication WILL NOT be administered if it is not in the original container. Please ask your pharmacist to provide two labeled bottles--one for home and one for school.

Please arrange medication administration outside of school hours if at all possible.

Student's name ____ Grade _______________

For the child named above, I request and grant permission to school personnel (medication will not necessarily be administered by the school nurse) to administer the above medication as ordered by the physician. I understand that it is my responsibility to furnish the medication and any medical equipment needed to administer the medication.

Signature of parent ____ Date ____________________

Daytime telephone number ____

PHYSICIAN DIRECTIONS

Name of medication to be given____

Dosage ____________________ Route _________________ Time/s ________________________________

Starting date ________________________________ Termination date _________________________________

Purpose of medication ____

Possible side effects:

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____ _____________________

Signature of Prescribing Physician Date

____ _____________________

Address of Physician's Office Telephone Number

At the close of the school year, a parent or legal guardian must claim any unused medication in the school office. Medication that remains unclaimed after June 1, 2011, will be discarded.