TRINITY CATHOLIC SCHOOL
AUTHORIZATION OF MEDICATION FORM
SCHOOL YEAR 2024-2025

PLEASE PRINT LEGIBLY AND NOTE THAT THIS FORM REQUIRES A PHYSICIAN SIGNATURE FOR PRESCRIPTION MEDICATIONS ONLY. OTC MEDICATIONS REQUIRE PARENT SIGNATURE ONLY.

I hereby certify that it is necessary for _____
Student's full name
Teacher/Homeroom:_____to be given the medication listed below during the school day, including when the student is away from school property on official school business. Without this medication, he/she cannot attend school.

NAME OF MEDICATION: _____

REASON FOR MEDICATION (DIAGNOSIS):_____

DOSAGE TO BE GIVEN: _____ **ROUTE (Mouth, Injection, etc.)**_____

TIME OF ADMINISTRATION: _____ **SIDE EFFECTS:**_____

BEGINNING DATE:_____ **ENDING DATE:**_____

Emergency Contacts:
Parent/Guardian: _____**(primary numbers)**_____
(Name)

Parent/Guardian: _____**(primary numbers)**_____
(Name)

Doctor's Name:_____ **Phone:**_____

Doctor's Signature/Stamp: REQUIRED: (Prescription Medications Only):_____

Prescription and Non-Prescription medications MUST come in the original container. Prescription labels will be the current, official pharmacy label and will designate the patient's name, dosage, and time of administration, the name of the medication, and the prescribing doctor. Changes in medication times or dosage can only be made by the prescribing physician, which may be faxed to the school. This permission form is for the current school year only. Medications left over will be discarded on the last day of school, if not picked up by parents.
I hereby consent to protected health information being used and disclosed to carry out treatment or health care operations for my child. I understand that Trinity Catholic School may need to give and receive protected health information pertaining to the management of my child's medical condition with the health care provider listed above, and I hereby authorize the exchange of this information as needed to carry out the treatment or health care operations of my child. I also give permission for the information on this form to be reviewed and utilized by the staff of this school and any school health personnel providing school health services at Trinity Catholic School for the limited purpose of meeting my child's health and educational needs.
It is understood by the undersigned that there shall be no liability for civil damages as a result of the administration of such medication where the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances. I also hereby agree to indemnify and hold Trinity Catholic School and the Diocese of Pensacola-Tallahassee harmless from any and all lawsuits, claims, demands, expenses, and actions against them arising from harm to any person caused by my child's actions with regards to a self-carried medication.

I am the parent/guardian of the child named above.

Date: _____ **Parent/Guardian Signature:**_____