



St. Junipero Serra Catholic School

23652 Antonio Parkway
Rancho Santa Margarita, CA 92688
Phone (949) 888-1990
FAX (949) 888-1994

MEDICATION ADMINISTRATION AUTHORIZATION

PHYSICIAN REQUEST FOR ADMINISTRATION OF MEDICATION:

Student's Name: _____ D.O.B. _____ Grade _____

Diagnosis/Reason for Medication: _____

Medication: _____

Dose: _____ Route: _____ Time: _____

Possible Reactions: (possible serious reactions with this medication, i.e. allergic reactions, localized/systemic, drowsiness) _____

Instructions for emergency care: _____

Disposition of pupil following administration of medication: (please check one)

☐ Rest ☐ Home ☐ M.D.'s Office ☐ Hospital ☐ Return to Class

The above medication cannot be scheduled for other than during school hours and this medication may be administered by non-medical school personnel.

Physician's Signature

(Office Stamp)

Address

Telephone #

Date of Request

Discontinue Date

This request is valid for the designated school year only.

PARENTAL AUTHORIZATION:

St. Junipero Serra Catholic School recognizes the desirability of following a physician's recommendation as nearly as possible at school. In so signing, parents or guardians agree to hold the school and/or its personnel/volunteers free from any or all suits which might arise out of these arrangements.

All medication must be supplied by the parent/guardian in the original pharmacy bottle or over-the-counter container and must indicate the student's name, dosage, frequency, and physician. All medication must be kept in the Health Room.

As a parent/guardian of _____, I request that the above medication be administered to my child at school in accordance with the written instructions of the child's physician.

Signature of Parent/Guardian

Date