ST. ANTHONY CATHOLIC SCHOOL

I authorize St. Anthony School to administer the following medication(s) to my child,

_____.

Name of Medication	Dose	Time to be Administered	Frequency	Reason for Medication

Additional instructions for administration of medication:_____

_____

Possible side effects to watch for:_____

_____

_____

Name of prescribing physician:_____Phone:_____

The medication container must have the original prescription label on it with the name of the child, physician date and instructions clearly visible.

_____ _____ _____

Parent's Printed Name | Parent's Signature | Date