St. Cyprian's
HEALTH SERVICES

PRESCRIPTION MEDICATION AUTHORIZATION

Student's Name:_____ DOB: ____/____/____ Homeroom:_____

I give my permission for SCES to give my child, _____, the following

MEDICATION: _____ DOSAGE: _____

WHEN TO GIVE: _____

REASON FOR MEDICATION:_____

I hereby release St. Cyprian's Episcopal School from liability to allergy or reaction to said medication.

_____ ____/____/____
Parent or Guardian Signature Date

MEDICATIONS MUST BE IN THE ORIGINAL CONTAINER WITH LABEL INTACT. The label must not be altered. Parent directions must match label directions. The dosage must be appropriate for your child's age.
NOTE: All medication will be kept locked in nurse's office. Asthma inhalers may be self-administered if deemed necessary by your doctor. Please have your doctor sign below if this is necessary or bring a note signed by him stating the need for your child to self-carry his/her asthma inhaler.

Due to the above-named student's medical condition, I am authorizing him/her to self-carry and self-administer his/her asthma inhaler.

_____ ____/____/____
Physician's Signature Date

ATTACH PRESCRIPTION CHANGES BELOW: