St. Timothy School
1070 Thomas Lane
Columbus, OH 43220

(614)451-0739
www.sttimschool.org

PRESCRIPTION MEDICATION AUTHORIZATION

In accordance with state law, both parent/guardian and physician must provide written consent for the administration of prescription medicine at school. A copy of this completed and signed form must accompany EACH medication.

Name of Student: ________________________________ Date of Birth: ___________

Grade/Homeroom teacher: ___________

TO BE COMPLETED BY PHYSICIAN:

______________________________ ______________________________
Name of Drug | Dosage, route, frequency

____
Instructions or precautions (include possible side effects)

/ / 20 - / / 20
____
Effective Dates

For Inhalers/Epinephrine: Student may carry ☐YES ☐NO
Student may self-administer ☐YES ☐NO
Adverse reaction for unauthorized use: ______________________

______________________________ ______________________________
Physician's Name | Address

______________________________ ______________________________
Phone Number | Fax Number

____
Physician Signature

TO BE COMPLETED BY PARENT/GUARDIAN:

I hereby give permission for the principal and/or his designee to administer the above medication as prescribed and further agree to:

1. Submit to school personnel a revised statement, signed by the physician, when any change to the above statement occurs.
2. Assume responsibility for safe delivery of medication to school, either by myself or by the student.
3. I release and agree to hold St. Timothy School, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

______________________________ ______________________________
Parent Signature | Date

______________________________ ______________________________
Preferred phone number | Secondary phone number