

St. John Bosco Catholic School

Health Care Provider and Parental Consent for Giving Non-Prescription Medications at School (for longer than 10 School Days)

Student Name: _____ DOB: _____

Grade: _____ Teacher: _____ Date: _____

A Physician, Nurse Practitioner, Physician Assistant, or Orthodontist (if braces related) must complete and sign below for the non-prescription medication you will provide for your child to be available for administration during school hours for a time period greater than 10 school days. A Parent/Guardian signature is also required. Medication must be delivered to the school in the original container with the label intact by an adult.

The medication is to be given in the following manner:

Name of Medication: _____ Strength of Medication: _____

Dosage: _____ Route: _____ Time: _____

Reason for Medication: _____

Start date: _____ End date: _____ Known Allergies: _____

Healthcare Provider: _____ **Signature:** _____

AZ License #: _____ Office Phone: _____ Date: _____

I authorize St. John Bosco Catholic School to administer the medication indicated above. I will assume full responsibility for the supply, appropriate transportation, and maintenance of above medication. If any changes in medication or dosage occur, the school must be notified immediately, and a new form must be completed.

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

Phone: _____ Date: _____