APPENDIX A.8

MEDICATION AUTHORIZATION

Date to begin Medication: _____/_____/_____Date to complete medication _____/_____/_____

Students Name: _____

School: _____Grade: _____

Part I – Completed by Student's Physician

I certify that this school must administer the medications listed below to my patient,_____
_____

- **Diagnosis: _____**
_____
_____

- **Medication(s): 1. _____2. _____3. _____**

- **Dosage/Model/Frequency:_____**
_____
_____

- **Possible Side Effects: _____**
_____
_____

_____ _____
Signature of Physician **Printed name of Physician**

(___) _____ _____
Physician Phone Number **Physician Address**

Appendix 8

Part II – Completed by Student's Parent / Guardian

I request that the medication listed above be administered to this student in school. I understand that only I, the school nurse, or a school employee trained by the nurse may administer this medication in school to this student.

I hereby release [school] and its employees, the Diocese of Metuchen, and the Bishop of the Diocese of Metuchen from any claims or liability connected with their reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance.

Signature of Parent/Guardian	Date:
Printed Name of Parent/Guardian	Relationship to child