Siena Catholic Academy
MIDDLE SCHOOL

Provider and Parent Permission to Administer Medication at School/School Sponsored Events

To Be Completed By Parent

Student Name: ____ DOB: _____________ Grade ___

I request the school nurse give the medication listed on this plan; or after the nurse determines my child can take their own medications; trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

____ _________________

Parent/Guardian Signature Date

To Be Completed By Health Care Provider-Valid for 1 Year

Diagnosis

____

Medication

____

Dose __________________________ Route _____________________ Time(s) ____________

Recommendations____

Possible Side Effects and Adverse Reactions (if any) ____________________________________

Note: Medication will be given as close to the prescribed time as possible, but may be given up to one hour before or after the prescribed time. Please advise if there is a time-specific concern regarding administration.

____ ______________________

Name/Title of Prescriber (Please Print) **Date**

____ ________________________

Prescriber's Signature **Phone**

2617 EAST AVENUE | ROCHESTER, NEW YORK 14610
TEL 585.381.1220 FAX 585.381.1223 sienacatholic.org