



## MEDICATION PERMISSION FORM HEALTH OFFICE

This form is to be completed by a licensed prescriber for each prescription or non-prescription medication that is to be administered while the student is attending St. John Paul II School.

**Please make additional copies and complete separate forms for each medication required.**

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### MEDICATION INFORMATION:

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Student Last Name	Student First Name	Student MI	Gender	DOB
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Parent/Guardian Last Name	Parent/Guardian First Name
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Date of Order	D/C Date	(OR) PRN
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Diagnosis

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Medication

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Dosage

Frequency

Route

Has the above named student received education about this medication including dosage, frequency, desired effects and possible side effects?  Yes  No

The above names student may be given, with parent permission  Tylenol and/or  Motrin

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### ADDITIONAL MEDICATIONS: (A separate form must be completed for each medication)

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Additional Medications(s) taken by this Student

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### LICENSED PRESCRIBER INFORMATION AND SIGNATURE:

*I Certify that, in my opinion, it is medically necessary for the above medication to be administered.*

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First Name	Last Name	Title
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Address	City	State
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Business Telephone	Business Fax
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Prescriber Signature	Date
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