

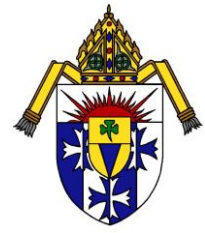


Montana Catholic Schools

The Diocese of Helena & The Diocese of Great Falls-Billings

www.diocesehelena.org ~ www.dioceseofgb.org

PO Box 4851 - Missoula, MT 59806



MEDICATION/TREATMENT AUTHORIZATION FORM

Prescribed Medication

Student's Name _____

Grade _____

Date of Birth ____ / ____ / ____

The following section is to be completed by the prescribing physician for prescription medication:

(A separate form must be completed for each medication or treatment prescribed)

The student named in this document is under my medical supervision for the diagnosis described below. I have prescribed the following medication/treatment, which is necessary to be given in school. I am aware that non-medical staff may administer this physician prescribed service.

This order is effective from: ____ / ____ / ____ **To:** ____ / ____ / ____

Diagnosis: (for this medication/treatment)		
Treatment:		
Name of Medication:	Brand Name:	Generic Name
Strength (i.e. mg/tab)		

Instructions to assist the student in the self-administration of the medication

Amount <small>(i.e. "2 tablets or 1 teaspoon"):</small>		Time(s): <small>(i.e. "10AM, Noon, and 2PM"):</small>	
Frequency <small>(i.e. "every 4 to 6 hours as needed for pain"):</small>		Duration <small>(i.e. "10 days")</small>	
Route:	<input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Inhaled		
	<input type="checkbox"/> Injection → → → <input type="checkbox"/> Subcutaneous <input type="checkbox"/> Intramuscular		
	<input type="checkbox"/> Other (describe)		
Time medication is given at home <small>(if applicable):</small>			
Possible side effects:			
Is student authorized to carry and use asthma inhalation medication or EpiPen? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has student been instructed in the use of asthma inhaler or EpiPen? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<small><i>The authorization for possession or self-administration of asthma, severe allergy, or anaphylaxis medication must be completed entirely by the parents and the physician for a student to be allowed to possess and/or self-administer asthma or severe allergy medication or an Epi-Pen.</i></small>			
Other Information:			

Physician Signature: _____ Date: _____

Physician Name: _____

Office Address: _____ Phone: _____

The following section is to be completed by the parent or legal guardian:

I hereby grant permission to the principal or his/her designee to assist in the self-administration of the prescribed medication and/or treatment to my child while in school and away from school while participating in official school activities. It is my responsibility to notify the school if and when these orders change.

Parent/Guardian name: _____ Relationship: _____

Phone #: _____ Phone #: _____

Signature: _____ Date: _____