

# Queen of Peace Academy

10900 SW 24<sup>th</sup> Ave. Gainesville, FL 32606  
Telephone (352) 332- 8808

## Authorization For Administering Medication At School

Student Name: \_\_\_\_\_

Grade/Teacher: \_\_\_\_\_

I request that a person delegated by the school principal give my child,  
\_\_\_\_\_ the following medication:  
(Child's Name)

Name of Medication			
Amount to be given			
Time of day to given			
Prescribing Physician			
Physician Phone Number			
Illness or condition prescribed/given for			
Dates medicine is to be given	From		To

Prescription medicine: **MUST** have original prescription label on the container; this label will include the child's name, medication, amount, frequency of administration, doctor's name, pharmacy's name and phone number.

Non-prescription medicine: **MUST** be in original container and marked with student's name.

I agree to furnish the school with this medication in the bottles as described above. I further understand that the school designated person will administer this medication to my child in good faith, at my request.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name (Mother)

\_\_\_\_\_  
Printed Name (Father)

Contact Information: Phone numbers:

Home: \_\_\_\_\_ Mom Cell: \_\_\_\_\_

Mom Work: \_\_\_\_\_ Dad Cell: \_\_\_\_\_

Dad Work: \_\_\_\_\_

Primary e mail address: \_\_\_\_\_