St. Peter Catholic School Parent/Guardian Medication Authorization & Provider Order Form

I hereby give permission to the school nurse or designee to administer the indicated medication(s) to my child as ordered by his/her licensed primary or specialty care provider. I understand that:

- It is my responsibility to have an adult transport the medication and check it in with the nurse or designee at the school.
- All over the counter medication must be labelled with student name and dosage information.
- All prescription medication must be in the original container from the pharmacy indicating student name, medication name, dosage, frequency, method of administration, and date of expiration.

If the prescribed medication is not administered for any reason at the school, 911 will be called for emergencies and parents will be notified for non-emergencies.
If my child participates in ICS before/after-school activities/sports, I assume responsibility for notifying the instructor/coach of my child's condition. I will provide extra emergency medication for the activity.
I hereby release St. Peter Catholic School and staff from any and all liability for damages or injury that may result from my child being administered the ordered medication.
I authorize the release and exchange of limited medical information between my child's licensed care provider, school nurse and St. Peter that is necessary in carrying out services for my child.

Student Name: _____Date of Birth: _____Grade/Class for 2025-26: _____

Parent/Guardian Name: _____Signature:_____Phone: _____ Date:_____

	Diagnosis	Medication	Dosage (mg)	Route	Time	Comments
Daily	___ADHD	_____	_____	_____By Mouth	Timing: _____	
Allergy Medications	Allergy: Allergen:	Diphenhydramine (Benadryl) _____ Other _____	___12.5 mg ___25 mg ___Other _____mg	By Mouth: ___Table ___Liquid ___Chewable	_____Upon Exposure _____Mild Reaction	Please Complete Allergy Action Plan:
	Emergency Allergy Medication:	Epinephrine Auto Injector	___0.15 mg ___0.3 mg	_____Intramuscular	_____Upon Exposure _____Severe Reaction	Please Complete Allergy Action Plan:
Asthma	Green Zone:	____Albuterol Other_____	___2 Puffs ___Other _____	_____Inhaler with Spacer _____Nebulizer	_____Before Exercise Other_____ _____	Please Complete Asthma Action Plan:
	Yellow Zone:	____Albuterol Other _____	___2 Puffs ___4 Puffs ___1 Vial __Other _____	_____Inhaler with Spacer _____Nebulizer	_____Every 4 Hours Other_____ _____	Please Complete Asthma Action Plan:
	Red Zone:	____Albuterol Other_____	___4 Puffs ___1 Vial ___Other _____	_____Inhaler with Spacer _____Nebulizer	_____Severe Symptoms Other_____ _____	Please Complete Asthma Action Plan:
Seizures	Type of Seizure:	___Valtoco ___Nayzilam Other_____	___5 mg ___10 mg ___Other _____mg	_____Nasal Spray _____Other	_____Seizure Onset _____After 5 Minutes After ___Minutes	Please Complete Seizure Action Plan:
PRN Meds	Pain/Other	_____Tylenol/Advil Other_____	_____mg _____mg	_____By Mouth _____Other	Timing: _____	

Provider Name: _____ Signature:_____ Phone:_____Date:_____Stamp:_____