ST. GREGORY THE GREAT
CATHOLIC SCHOOL

AUTHORIZATION FOR MEDICATION ADMINISTRATION

2024-2025

I/we authorize that my/our child be facilitated in accessing the prescription (or non-prescription) medications listed below, for the purpose of self-administering, according to the designated guidelines (EDUCATION CODE SECTION 49423):

Student's Name: _____ Date: _____

Date of Birth: _____ Grade: _____

- Prescribed medication must be in the original container with the original label affixed to the container.
- Non-prescription/over the counter medication accepted with this form.
- Medication will be kept by school personnel until the student needs/requests to use it.
- Any change in prescription requires a new written order from the Physician prescribing the medication. Verbal/email orders are not accepted.

Signature of this form releases and holds school personnel harmless from any and all liability for damages or injury resulting directly or indirectly from the presence of the medication in the school or its use by my child.

_____ _____ _____

Parent/Guardian Name (PRINT) Parent/Guardian Signature Date

MEDICATION	DOSAGE	TIME	START DATE	END DATE	REASON FOR MEDICATION

_____ _____ _____

Physician Name (PRINT) Phone Number Date