



SAINT MARY'S
CATHOLIC HIGH SCHOOL

Medication Administration Permission Form 2024-2025

Student Name:	Grade:	Date: / /
Parent / Guardian Name:		
**Parent / Guardian Signature:		

*** All unused medication needs to be picked-up at the end of the school year.
If the medication is not picked-up, it will be donated.*

Over the Counter Medication

- **All medication must be provided by parent / guardian.**
- Medication must be in original container with an expiration date.
- Complete the table below. Be sure to include the amount that is to be administered.

I am providing the following medication to be given to my child during the school day:

	Medication	Amount to Give
<input type="checkbox"/>	Ibuprofen (ex. Motrin, Advil)	Dose: _____ mg _____ tablets/tsp.
<input type="checkbox"/>	Acetaminophen (ex. Tylenol)	Dose: _____ mg _____ tablets/tsp.
<input type="checkbox"/>	Diphenhydramine HCl (ex. Benadryl)	Dose: _____ mg _____ tablets/tsp.
<input type="checkbox"/>	Cough drops	Dose: _____ lozenges per day
<input type="checkbox"/>	Other Medication:	Dose: _____ mg _____ tablets/tsp.
<input type="checkbox"/>	Other Medication:	Dose:

Prescription Medication

Medication:	Dose:
Time to Give:	
Reason for Medication:	
Name of Prescriber:	

For questions, please reach out to Ms. Donna Heldt at dheldt@smknights.org, or (602) 251-2518.