St. Petersburg Catholic High School

Authorization for the Administration of Medications

All medications must be sent to the school clinic in a labeled prescription container or the original container

Date_____

Student's Name_____

Name of Medications	Dose	Time/Special Instructions

I give permission for SPCHS to administer the above medications to my son/daughter. I understand that this medication will be secured in the school clinic and will be available to my child at any time during the school day.

Parent/Guardian Signature_____

Phone Number during the day_____