

Archdiocese of San Antonio
Catholic Schools Office
MEDICATION PERMISSION REQUEST FORM

According to the policies of the Archdiocese of San Antonio, students are not allowed to carry medication on their person, including non-prescription medications. (The only exception is that, by physician direction, a student may be allowed to carry and self-administer inhaler medication). Medications will be maintained and dispensed by appointed school health coordinators. The following steps must be taken before a student is allowed to take medication at school:

1. Parent/guardian must present this completed consent form to the school
2. Parent/guardian must bring the medication in the original prescription bottle, properly labeled by a registered pharmacist as prescribed by law.

Medication may be given by school personnel provided that the prescribing health care provider completes this form.

Name of student: _____ Grade: _____

Date of birth: _____ School: _____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Medication #1

Name	Strength	Dose	Time (at school)	Route

Medication #2

Name	Strength	Dose	Time (at school)	Route

Medication #3

Name	Strength	Dose	Time (at school)	Route

Allergies: _____

Special instructions: _____

Printed Name of Health Care Provider	Signature of Health Care Provider	Date

TO BE COMPLETED BY PARENT

I, _____, request that my child be given the above medication as directed. (Printed Name)

Signature of parent/guardian: _____ Date: _____

Telephone: (Home) _____ (Work) _____ (Mobile) _____

ARCHDIOCESE OF SAN ANTONIO

Physician's and Parent's Certificate for Athletics

Student's Name: _____ Date of Birth: _____

School: _____

PHYSICIAN'S REPORT

Height:	Weight:	Body Type:	Eyes:	Ears:
Nose:	Throat:	Hearing:	Heart:	Lungs:
Blood Pressure:				

JOINT FUNCTIONS

Shoulders: _____ Elbows: _____ Hips: _____ Knees: _____

DENTAL – Circle Defect

Cavities Bridges False Teeth Retainer Appliance

SKIN

Fungus _____ Staph _____ Neuromuscular _____

Genito-urinary _____ Hernia _____

Is student taking any medications routinely? Yes _____ No _____

Explain: _____

I hereby certify that on this date I have examined the above student as indicated by items checked and recommend him/her as being physically able to participate in the supervised activities that are not circled below.

Basketball Cheerleading Cross Country Soccer Softball Track & Field Volleyball

Date _____ Signature of Examining Physician: _____

I hereby give permission for the above student to compete in Archdiocesan approved sports, and go with the coach or other representative on any trips. The parent herewith grants permission for school employees to secure medical services for the above student if necessary. The undersigned agrees to be responsible in the safe return of all athletic equipment issued by the school to the above named student.

Date: _____ Signature of Parent/Guardian _____

Evidence of Student Insurability: _____

Health Insurance Company: _____ Policy Number: _____