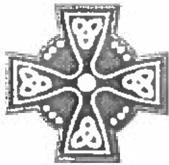

SAINT PATRICK SCHOOL

TO KNOW GOD, TO LOVE GOD, TO SERVE ALL

Student's Name ____________________ ______________ __
Last Name First Name MI

Date of birth ____/____/______ Grade __________

Directions for OTC medication

St. Patrick School is directed to give to ____________________
(Name of Child)

his/her medication ______________________________
(Name of medication)

in a dosage amount of ____________________________
______________________________ (how much)

at a frequency rate of ___________________________
__________________________ (how often & when)

over the course of ________________ days duration.

☆☆This authorization form is good for 7 days starting on the date signed below. The authorizing parent signature must match the parent signature on file in the school office.

Signature of Parent ______________________________

Date____/____/______ Telephone Number ____________

IMPORTANT: St. Patrick School policy states that all medications must be brought to school by parent/guardian in the original container.

To Know God, To Love God, To Serve All

4333 Parnell Avenue, NE • Ada, Michigan 49301 • Phone: 616.691.8833 • Fax: 616.691.6309
www.stpatrickparnellschool.org