



**St. Mary's School**  
**903 W. Mission Avenue**  
**Bellevue, NE 68005-3998**

Phone: 402-291-1694  
 Fax: 402-291-9667

**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION**  
**2009-2010**

All medication must be brought in the prescription container with the original pharmacy label. Prescriptions must be labeled with the student's name, date, and name of medication, medication dose and time to be given. Medication **WILL NOT** be administered if it is not in the original container. Please ask your pharmacist to provide two labeled bottles – one for home and one for school.

**Please arrange medication administration outside of school hours if at all possible.**

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_  
 Date of Birth \_\_\_\_\_

For the child named above, I request and grant permission to school personnel (medication will not necessarily be administered by the school nurse) to administer the below medication as ordered by the physician. I understand that it is my responsibility to furnish the medication and any medical equipment needed to administer the medication.

Signature of parent \_\_\_\_\_ Date \_\_\_\_\_  
 Daytime telephone number \_\_\_\_\_

**PHYSICIAN DIRECTIONS FOR USE OF ASTHMA MEDICATION**

Name of medication to be given \_\_\_\_\_ Physician Action Plan Attached  Yes  No

Start date \_\_\_\_\_ Termination date \_\_\_\_\_

1. Nebulizer Dosage:  1 premixed vial  other \_\_\_\_\_
2. Inhaler Dosage:  1 puff  2 puffs  other \_\_\_\_\_
3. To be administrated:  q 2-4h  q 4-6 h  prior to exercise  prn  
 other \_\_\_\_\_  If no improvement medication may be repeated after 15 minutes

Possible side effects: \_\_\_\_\_  
 \_\_\_\_\_

Signature of Prescribing Physician \_\_\_\_\_ Date \_\_\_\_\_

Address of Physician's Office \_\_\_\_\_ Telephone Number \_\_\_\_\_

*At the close of the school year, a parent or legal guardian must claim any unused medication in the school office. Medication that remains unclaimed at the end of school year will be discarded.*