St. Matthew School Request to Administer Medication to
STUDENT DURING THE SCHOOL DAY
2026-2027

If it becomes necessary for a student to take medication or receive treatment during the school day, the parent or guardian must complete this request form and file it in the school office. If the medication or treatment is physician-prescribed, the parent or guardian must provide a written prescription from the child's physician or the current pharmacy label with the request. A physician's order is also necessary for prescription samples that may have been provided to the student, or for any over-the-counter medication that is not recommended for children under age twelve.

All other over-the-counter medication must be FDA-approved, & in the original container labeled with the student's name and date of birth. Label instructions will be followed for all over-the-counter medicine unless otherwise prescribed by a physician. Further medication administration policies and protocols are to be read and agreed to by a parent/guardian prior to medication administration by school staff. These policies are found on our website or by request.

Parent's or Guardian's Authorization

I request that the medication described below be administered to my child/ward at the times specified during the school day. I will give the office staff the medication in its original container or current prescription bottle.

I understand that a parent or guardian will transport all medication to and from school. Medications must be picked up by the last day of school, or medications will be discarded.

I understand that a separate form must be completed for each medication. This request is in effect for one school year and must be renewed annually or whenever there is a change in medication.

I understand that this medication will be administered to my child only by authorized staff members and will be kept in a secure location within the school office.

_____ Student's Date of Birth: _____/_____/_____
Student's Name (Please Print) Month Day Year

_____ Prescribed _____ Over-the-Counter _____
Name of Medication

_____ Times(s) to administer _____a.m. _____p.m.
Days Medication to be given

_____ _____
Amount of Medication to be given Diagnosis for this medication

_____ _____
Signature of Parent or Guardian Date

_____ _____/_____
Printed Name Primary Phone# / Secondary Phone#

❒ This medication is a controlled substance. I understand that this medication will be counted for safety and security documentation and a parent/guardian signature is required on the medication log.