PHYSICIAN AND PARENT REQUEST

FOR THE ADMINISTRATION OF PRESCRIPTION MEDICATION

BY SCHOOL PERSONNEL

School: Holy Rosary School Grade/Class: _____

Name of Student: _____ Diagnosis: _____

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PART 1: PRESCRIPTION MEDICATION TO BE TAKEN—TO BE COMPLETED BY PHYSICIAN

Medication: _____ Dosage: _____

Dosage Time/Intervals: _____

Administration to Begin: _____ Administration to End: _____

Severe Adverse Reaction to be Reported to the Physician: _____

_____

Special Instructions for Administration of the Drug and/or Sterile Conditions or Storage: _____

_____

Name of Physician: _____

Address of Physician: _____

Phone Number: _____ Emergency Number: _____

Signature of Physician: _____

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PART II. TO BE COMPLETED BY PARENT/GUARDIAN AND RETURNED TO SCHOOL PRINCIPAL

I request the above described medication be administered to my child according to the instructions provided, and I agree to deliver the medicine to the school in the container in which it was dispensed by the prescribing physician or licensed pharmacist. If the above information changes, I will submit a revised statement signed by the physician.

Signature of Parent/Guardian: _____ Date: _____

Address: _____

Home Phone: _____ Cell Phone: _____

The school will not assume the responsibility for administering injections, applying ointments, or changing dressings. The student will be responsible for requesting medication.

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PART III: TO BE COMPLETED BY THE SCHOOL

Date Received: _____ Signature of Administrator: _____

Person authorized to give medication for this student: _____

Signature of School Nurse: _____ Date: _____ 4/15

PARENT REQUEST

FOR THE ADMINISTRATION OF NON-PRESCRIPTION MEDICATION (OVER THE COUNTER)

BY SCHOOL PERSONNEL

School: Holy Rosary School Grade/Class: _____

Name of Student: _____ Diagnosis: _____

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PART 1: NON-PRESCRIPTION MEDICATION TO BE TAKEN

Medication: _____ Dosage: _____

Dosage Time/Intervals: _____

Administration to Begin: _____ Administration to End: _____

Special Instructions for Administration of the Drug and/or Sterile Conditions or Storage: _____

_____

Name of Physician: _____

Address of Physician: _____

Phone Number: _____ Emergency Number: _____

Signature of Physician: _____

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PART II. TO BE COMPLETED BY PARENT/GUARDIAN AND RETURNED TO SCHOOL PRINCIPAL

I request the above described medication be administered to my child according to the instructions provided, and I agree to deliver the medicine to the school in the container in which it was dispensed . If the above I information changes.

Signature of Parent/Guardian: _____ Date: _____

Address: _____

Home Phone: _____ Cell Phone: _____

The school will not assume the responsibility for administering injections, applying ointments, or changing dressings. The student will be responsible for requesting medication.

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PART III: TO BE COMPLETED BY THE SCHOOL

Date Received: _____ Signature of Administrator: _____

Person authorized to give medication for this student: _____

Signature of School Nurse: _____ Date: _____ 4/15