Student's Name ______________________________ Discontinue Date _________________

MEDICATION ADMINISTRATION REQUEST

This form must be completed by the parent/guardian in order for any medication to be administered at school. It is the parent/guardian's responsibility to see that the school personnel receive this authorization. All medications, whether prescription or over-the-counter, must be registered with school office personnel, and ***not* with the classroom teacher.**

Medication sent to school with students will not be given until a parent/guardian completes this form.

Prescription Medication: Prescription medication must be in a *current*, non-expired, pharmacy labeled container. The label must indicate student's name, doctor, date, name of medication, dosage, and time to be given.

Non-prescription Medication (over the-counter): Medication must be in its original container and not be beyond the expiration date. Over-the-counter medications must be dispensed according to the label unless otherwise directed in writing by a physician. Manufacturers' labeling and student's bane must be clearly printed and **legible**. The school personnel designated to give medication have the authority to refuse to administer any medication if, in his/her judgment, it is not warranted.

Due to the variable nature and schedule of the school office, it is possible that a student might miss a dosage.

It is possible that a student's medication supply can be depleted before the parent/guardian is notified. Therefore, it is the parent/guardian responsibility to count out and ensure that prescription medication is kept in supply at school.

Medication WILL NOT be administered if it is not in the original container. **Please ask your pharmacist to provide 2 labeled bottles – one for home and one for school.** Parent/guardian must also provide an **appropriate dosage measuring device for liquid medication.**

PLEASE PRINT CLEARLY

Student Name _____________________________________ **Grade** ______ **Today's Date** __________

Name of Medication ____________________________________ **Prescription Number** _______________

Reason for Taking ____

Time of Administration: ___________ **A.M./P.M.** ___________ **A.M./P.M.** __________ **A.M./P.M.**
(1st dosage) (2nd dosage-if applicable) (3rd dosage-if applicable)

Start Medication on: _______________________ (Date)

Discontinue Medication on: _____________________ (Date) (Maximum of 2 weeks)

Do you want lunch medication given on half days when **NO** lunch is served? _____ YES _____ NO

Does medication require refrigeration? _____YES _____NO

Potential side effects/reactions:____

Action advised in case of reaction: ____

Pharmacy Name: ____ **Telephone:** ___________________________________

Physician: ____ **Telephone:** ___________________________________

I authorize school personnel to assist my child in taking the above medication during school hours. I understand that additional parent signed statements will be necessary if the dosage or times of the medication are changed. I understand that I am responsible for supplying this medication to the school in the original container and that it is my responsibility to pick up any unused medications. I understand the school is not legally obligated to administer to any pupil and, therefore, agree to hold St. Catherine of Siena School harmless from any and all liability resulting from the administration of the medication in the manner directed.

Parent/Guardian Signature: ____ **Date:** ___________________