St. Dominic School
2009-2010

PARENT'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I hereby request, authorize and give my permission to the principal or his/her designee, (e.g., school nurse or responsible person) to administer the following medication to my child.

Prescribed medication:

____

(See Physician's completed request form attached)

Non-prescription medication:

____

(Over the counter)

____

Name of Student   Date of Birth

____

Address   City   State   Zip Code

____

Name of prescribed drug , dosage and route of administration

____

Times of day to be administered

Beginning and expiration date of this request:

____

It is not possible for this medication to be taken at home by my son/daughter, and it must be administered during the school day.

In consideration of my child being administered the above specified medication at my request, on behalf of my child, my spouse, and myself. I hereby assume all risks in connection therewith, and I further release the Diocese of Cleveland, the Bishop of the Roman Catholic Diocese of Cleveland, ____St. Dominic____ School, ____St. Dominic____ Parish, employees and volunteers from all claims, judgments, liability for any injury or damage due to the designated administration of said medication to my son/daughter.

____

Parent/Guardian Signature   Date

NOTE: This form should be updated not less than once each school year.

St. Dominic School
2009-2010

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

______________________________, ___________ who resides at ________________

Name of Student   Date of Birth   Street

______________________________, is under my care and should receive the

City, State, Zip Code

Following medication indicated below:

______________________________ ______ ______________________________

Name of prescribed drug   Dosage   Number of time/intervals for administration

Special instructions for administration:

____

____

Reaction(s) and/or possible side effects to be reported to physician:

____

____

Beginning and expiration date of this request: ______________________________

It is not possible for the above specified medication to be taken at home under the supervision of a parent and it is, therefore, necessary that the specified medication be administered during school hours. The medication provided shall be in the original container obtained by the parent/guardian from the pharmacist. This medication can be safely administered by non-medical personnel.

____

Physician's Name   Physician's Signature   Date   Telephone

NOTE: This form should be updated no less than once each school year.