



Cathedral Preparatory School
 225 West 9th Street
 Erie, PA 16501
 p: 814-453-7737
 f: 814-453-6180
 www.prep-villa.com

Villa Maria Academy
 2403 West 8th Street
 Erie, PA 16505
 p: 814-838-2061
 f: 814-836-0881
 www.prep-villa.com



MEDICATION / TREATMENT AUTHORIZATION TO BE COMPLETED BY THE PARENT/ GUARDIAN

I request that my child, _____ Grade _____
 be assisted in taking medications described below at school by authorized persons. I understand that I am responsible for submitting the medication in a proper and timely manner and that, if necessary, the school may request additional information from the physician regarding this medication. I agree to abide by the regulations on the reverse side of this form and I understand that this form must be renewed annually and anytime there is a change in drug, time, or dosage.

I agree to waive Cathedral Preparatory School, its administration, representatives, and employees from any and all liability, claims, demands, and causes of action arising out of or in any way connected with the giving of the prescribed medication or treatment. The undersigned parent or guardian hereby assumes all risks of injury or damage to the minor child receiving prescribed medication or treatment during school activities, and specifically waives any claim for acts of negligence by employees of Cathedral Preparatory School.

Furthermore, as parent or guardian of the minor child to receive the prescribed medication and/or treatment, the undersigned hereby expressly agrees to indemnify and forever hold harmless Cathedral Preparatory School, its administration, representatives, and employees against and loss or any claims, demands, or causes of action that might be brought by the minor or on his behalf to defray damages incurred by the taking of the prescribed medication and/or treatment given by Cathedral Prep during regularly scheduled school hours or activities of Cathedral Prep. As parent or guardian, I hereby waive all exemption rights under all state laws against any claims for reimbursements or indemnification.

Name of medication/ treatment _____

Diagnosis (reason) for which medication/ treatment is given _____

Dosage _____ Time _____

Date _____ Parent/ Guardian Signature _____ Daytime Phone _____

TO BE COMPLETED BY THE PHYSICIAN:

Name of medication/ treatment _____

Diagnosis (reason) for which medication/ treatment is prescribed _____

Dosage _____ Time _____

Can this medication/ treatment be adjusted to accommodate class schedules? _____
 If so, by how much? _____

List significant side effects _____

If medication is to be given "prn", describe indications and intervals _____

Other information _____

Is it medically necessary for this student to carry his inhaler/epi-pen with him at all times? _____

Is this student qualified and able to self administer his inhaler/epi-pen? _____

From _____ to _____
Dates medication/ treatment is to be given Physician Signature

Note: Any alterations to the printed portion of this form will render it null and void.

MEDICATION GUIDELINES

If at all possible, medication should be administered at home. Medications will be administered during school hours only when failure to take such medication would jeopardize the health of a student and he would not be able to attend school if the medication were not made available. All medications are dispensed from the Nurse's Office or Main Office. STUDENTS ARE NOT TO CARRY MEDICATION WITH THEM DURING SCHOOL HOURS. In order for school employees to dispense medication, the following requirements must be met:

For Prescribed Medication:

1. We must receive written authorization from the physician and parent/guardian stating what the medication is, what it is for, the dosage, and the time it is to be given.
2. We must receive the medication in a current, properly labeled prescription bottle or original container.

For Non-Prescribed Medication:

1. We must receive written parental permission stating what the medication is, what it is for, the dosage, and the time it is to be given.
2. We must receive the medication in the original container.
3. A maximum of 14 doses of non-prescribed medication can be administered.

Each change in medication (dosage, time, kind, etc.) throughout the year requires a new authorization form signed by both parent/guardian and physician where applicable. Forms must be renewed annually.

Students are responsible to report to the Nurse's Office or Main Office to receive their medication at the proper time.

Medication for Field Trips

If your student is going on a field trip, please make arrangements for him to not to take medication. If it is necessary for him to take daily medication, put the dose clearly marked on an envelope with the student's name, name of medication, and the time it is to be given. Seal the envelope and make sure the teacher receives it. Also notify the School Nurse and Main Office so they know not to administer the medication that day. Do not ask the Nurse or Main Office to take a dose from your child's supply at school to send on the trip. This constitutes "relabeling medication" and is not permitted. Please call the School Nurse with any questions.