CATHOLIC HIGH SCHOOL

PHYSICIAN FORM

ADMINISTERING OF MEDICATION

TO BE COMPLETED BY LICENSED PHYSICIAN OR DENTIST:

I hereby certify that it is medically necessary for _____ to receive medication during school hours.
(Student's name)

1) Diagnosis: _____

2) Medication to be administered: _____

3) Dosage: _____

4) Time of day to be administered: _____

5) Duration of medication order: _____

6) Possible side effects of the medication: _____

_____

7) Any contra-indication for administering medication: _____

_____

_____ _____
(Physician's signature) (Date)

_____ _____
Print Name of Physician Physician Office Number

This form may be faxed to the school : (337) 364-5041

1301 DE LA SALLE DRIVE - NEW IBERIA, LOUISIANA 70560 - (337)364-5116

CATHOLIC HIGH SCHOOL

Parental Release Form

REQUEST FOR SCHOOL PERSONNEL TO ADMINISTER MEDICATION

Please complete all information on this form and return it to the school office

1) Child's Name: _____

2) Medication to be administered: _____

3) Dosage: _____

4) Purpose of medication: _____

5) Time of day medication is to be administered: _____

6) Anticipated number of days medication needs to be given during school hours: ____

_____

7) Possible side effects: _____

_____

(Signed physician statement must accompany this request form)

I hereby release, relieve, and discharge the Catholic High School staff and its employees from any and all liability for any injury or damage to the health of said child arising out of or resulting from the necessity of said child having to take medication during school hours.
My signature authorizes school personnel to administer the prescribed medication, as stated on this form, to my child.

_____ _____
(Parent Signature) (Date)

_____ _____
Daytime phone number Cell number

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