BISHOP O'GORMAN CATHOLIC SCHOOLS

HEALTH SERVICES REQUEST FORM – B

Administration of Medication During the School Day

AUTHORIZATION MUST BE SUBMITTED ANNUALLY

Parents of students requesting that medication be administered during school hours by school staff are required to provide the following information:

1. The Physicians Order (Section I. below) – Waived for temporary conditions (e.g. pain medication for wisdom teeth or broken bones, antibiotics for strep throat, etc.)
2. A Parental Release (Section II. below) – Required for any medication dispensing
3. Medication supplies in the original, properly labeled container (*Ask pharmacy for prescription medication to be divided in two containers completely labeled – one for home and one for school*)

Student Name: _____ Date of Birth: _____

Grade/Class: _____ Date: _____

Address _____ Phone: _____

I. PHYSICIANS ORDER FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I have prescribed the following medication for this child and request the dosages be given during school hours:

Medication:	Dose:
Time:	Route:
For Treatment of:	
Possible Side Effects:	
Special Instruction:	
Timeline: (start date)	(end date)
Medication Allergies:	
Physicians Name (print):	
Physicians Signature:	
Physician Address:	Phone #:
Date:	

II. PARENTAL RELEASE

I request this medication be given as prescribed and the above information be released to the physician as requested. I release school personnel from any liability in relation to the administration of this medication at school. I understand that medication will not necessarily be administered by a school nurse. (Please check appropriate responses below.):

☐ **Keep this medication at school** ***OR*** ☐ ***Send this medication home each evening***

Physician and I agree that this student needs this medication on field trips: ☐ Yes ☐ No

Parent/Guardian Name (print):

Parent/Guardian Signature:

Date: