



MEDICAL FORM FOR ADMINISTRATION OF MEDICATION AND SELF MEDICATION ADMINISTRATION

Catholic. CoEd. College Prep. This form is good for up to one year.

The following is to be completed by a licensed health care provider. No medication of any kind will be given to your child until this information is completed and returned to school. The parent/guardian may complete the health-care provider section for non-prescription medication.

- All medication must be in a pharmacy-labeled container. NOTE: Over the counter medication must be brought to school in an unopened original container.
If any changes in medication occur during the school year, a new form must be completed along with a new pharmacy-labeled container and returned to the school.
Only one form for each medication is to be used.
Medication must be brought to school by a responsible adult. Please do not send medication with children.
Any unused medications will be destroyed at the end of the current school year if not retrieved by the parent/guardian.

TO BE COMPLETED BY PARENT:

St. Benedict Student's Name Date of birth Grade Level

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the St. Benedict and its employees and agents, on my behalf to administer to my child (or allow my child to self-administer, while under the supervision of the employees and agents of the School), lawfully prescribed medication in the manner described. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices, I agree to indemnify and hold harmless the School and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

Parent /Guardian (Please Print) Parent/Guardian Signature

Date Mother's Cell Phone Father's Cell Phone

Emergency Contact's Name Cell Phone

TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY:

Diagnosis for which medication is given

Name of medication Dosage Start Date Stop Date

Form Route Special Handling Instructions

If medication is to be given daily, at what time(s)?

Dates must be administered at school: Every day at school As needed only

If medication is to be given "when needed," describe symptoms student will exhibit

How soon can it be repeated? Possible side effects, if any

Healthcare Provider Name (Print) Healthcare Provider Signature

Date Address Zip Code Phone Fax

TO BE COMPLETED BY ST. BENEDICT'S STAFF ONLY

Completed form received on By