

**PRESCRIPTION MEDICATION ADMINISTRATION POLICY AND FORM**

1. Parent must bring medication to the school office.
2. Medication must be accompanied by this form filled out by the parent **AND the physician** – Physician order may be faxed in on physician’s letterhead directly to the school (356-9293).
3. The medication must be in the original container.

**PARENT’S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL**

I hereby request and give my permission to the school nurse or her delegate to administer the following medication to my child.

Name of child \_\_\_\_\_ Grade/Teacher \_\_\_\_\_

Name of drug \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

Give drug at the following time \_\_\_\_\_

Parent signature \_\_\_\_\_ Date \_\_\_\_\_

I understand that school policy permits staff other than the school nurse to administer medications. Accordingly, I understand that the person administering the medication may or may not be trained or experienced in the administration of medications. I knowingly consent to these procedures and request that the medication be administered.

**RELEASE OF LIABILITY/ HOLD HARMLESS**

In consideration of Saint Henry School administering the above-requested medication to my child \_\_\_\_\_, I hereby acknowledge that the school, its officers, staff, directors, faculty, school nurse, and employees are not responsible for reactions to the medication, improper dosage in the medication, etc., and will only be responsible for injuries relating to negligent physical administration of the medication.

\_\_\_\_\_  
Parent signature \_\_\_\_\_ Date \_\_\_\_\_

**PHYSICIAN’S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL**

\_\_\_\_\_ is under my care and should receive  
Name of student \_\_\_\_\_

\_\_\_\_\_ at the following times: \_\_\_\_\_  
Name of drug, dosage, route \_\_\_\_\_

Specific instructions for administration: \_\_\_\_\_

Possible side effects to watch for: \_\_\_\_\_

Expiration date of this request: \_\_\_\_\_

Physician name-PRINT \_\_\_\_\_ Phone \_\_\_\_\_

Physician signature \_\_\_\_\_ Date \_\_\_\_\_