

Medication Consent Form

PLEASE NOTE: The parent/legal guardian must bring the medication to school in a container that is appropriately labeled by a pharmacy or physician.

TO BE COMPLETED BY PHYSICIAN/NURSE PRACTITIONER/DENTIST:

Student's Name _____

Student's Date of Birth _____ Grade _____

Diagnosis _____

Medication _____

Dosage, Time of Administration, Route of Administration and other Instructions: _____

Start Date _____ End Date _____

Physician/Nurse Practitioner/Dentist's Name (PLEASE PRINT) _____

Physician/Nurse Practitioner/Dentist Signature/Date _____

Medical Office Phone Number _____

Guidelines:

1. Whenever possible, avoid prescribing medication for administration during school hours, especially medications to be administered for a short period of time.
2. Medications must be in containers issued and labeled by a pharmacy or physician. These will be kept under lock and key in the school clinic.
3. Carrying of inhalers by students is discouraged unless ordered by the physician. Such items are easily stolen, lost or forgotten at home, leaving the student in a dilemma and possibly in a medical crisis.
4. Any change of prescription requires a new written order from the prescribing physician.
5. St. Patrick Catholic School can be contacted by phone (440-5500) or fax (440-5200).
6. Students are not allowed to transport medication on their person to and from school.

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN: I hereby give permission for the school to administer the medication as prescribed above. I give permission for the school nurse to share the above medication information to any school personnel as necessary for my child to receive the proper care. I also give permission for the school to contact the above health care provider regarding the administration of this medication.

Name of Parent/Legal Guardian

Phone Number

Signature of Parent/Legal Guardian

Date