PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF PRESCRIPTION MEDICATION BY SCHOOL PERSONNEL

Student's name: _____ DOB: _____

Student's address: _____

School where student is enrolled: _____

The Student is under my care and should receive the following medication(s):

_____

(Insert name of drug and dosage administered above)

The times or intervals at which each dosage of the drug shall be administered:

_____

The date the administration of the drug is to begin and end:

_____

Specific instructions for administration of drug (including sterile conditions and storage):

_____

Possible side effects to watch for:_____

_____

Severe adverse reactions that must be reported to physician at emergency phone number below: _____

_____

_____ _____
Physician's Signature Date

_____
Physician Print Name

_____ _____
Physician's Phone Number Physician Emergency Phone Number

Parent/Guardian

I request and give my permission to the principal or his/her designee (school nurse or other responsible person) to administer the above-mentioned medication to my child. I agree to immediately submit a revised version of this form signed by my child's physician if any of the information contained above changes. I, individually and as the parent/guardian of the student mentioned above, release, indemnify, and hold harmless the Archdiocese of Cincinnati, the Archbishop of Cincinnati, the School, the Parish, and their employees, agents, and religious from any liability, claim, damage, cost, expense, or fee that arises, directly or indirectly, out of the presence of the medication in the School or its use by the student.

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Print Name

_____ _____
Parent/Guardian Phone Number Parent/Guardian Emergency Phone Number