REQUEST FOR THE ADMINISTRATION OF MEDICATION AT ST. PETER SCHOOL

St. Peter Catholic School
6185 Chambersburg Road Huber Heights, OH 45424
Phone (937) 233-8710 Fax (937) 237-3974 Clinic (937) 233-5964

Date Form Received by School: _____ Student Name: _____

Grade: _____ Teacher: _____ Student Date of Birth: _____

❖ **Part I – To Be Completed by Physician or Prescriber:**

Reason for Medication: _____

Medication: _____ Dosage: _____ Amount: _____

Time(s) to be Given: _____

(any change in dosage or schedule requires a physician's written order)

Start Date: _____ Stop Date: _____ Other Date/Duration: _____ or ☐ End of School Year

Restrictions and/or Important Side Effects:

☐ None Anticipated ☐ Yes. Please Describe: _____

_____

Special Storage Requirements: ☐ None ☐ Refrigerate ☐ Other _____

(All Medications Are Stored in Locked Cabinets.)

To Physician: If Inhaler or Epi-Pen medication is to be carried by student. 1) This students is both capable and responsible for self-administering this medication?: _____ No _____ Yes – Unsupervised 2) This student may carry this medication?: _____ No _____ Yes If yes, this student has been instructed in the proper administration and consequences of inappropriate administration. Procedure to follow if medication does not produce the expected relief: _____

Adverse reactions for unauthorized user: _____

_____

Date: _____ **Physician's Signature:** _____

(Please Print) Physicians' Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

❖ **Part II – To Be Completed by Parent(s) or Guardians(s):**

We (I) understand that the administration of said prescribed oral medication is to be done under the supervision of a medically untrained member of the adult school staff.

Further, we (I) understand that the school personnel are not legally obligated to administer oral medication to any child and, therefore, we (I) agree to hold the school district and any and all of its employees free from any and all responsibility for the results of these arrangements, including any civil judgment which may be rendered against them.

Further, we (I) agree to deliver the medication to the school in the original container from the prescribing physician or licensed pharmacist, properly labeled by same, this label to include name of student, physician, date, dosage instructions quantity and times), and name of medication.

Further, we (I) will notify the school immediately if we change physicians or medication or discontinue the use of this medication for any reason, and will report immediately to the school to pick up the remainder of said medication.

. . . . . .

give permission for (name of student) _____ to receive the above medication at school according to St. Peter School policy. (in case of joint custody, both parents must sign form.)

Date: _____ Signature: _____ Relationship: _____

Phone: Home _____ Work _____ Cell _____

Date: _____ Signature: _____ Relationship: _____

Phone: Home _____ Work _____ Cell _____

Medication Order Reviewed at St. Peter School Clinic by: _____ Date: _____