St. Patrick School Medication/Procedure Form

Medications are to be administered at home whenever possible. If it is necessary to receive medications at school, all appropriate portions of this form must be completed before medications can be given by the school.

Student _____ Grade _____ Birthdate _____

Address _____

Mother _____ Mother Phone ( ) _____

Father _____ Father Phone ( ) _____

Physician _____ Physician Phone ( ) _____

MEDICATION/PROCEDURE

Name of Medication/Procedure _____

Reason for Medication/Procedure _____

Time(s) to be given at school _____Date(s): From ___/____/____ To ___/____/____

Dose _____ Route: Mouth ____ Inhaled ____ Injected ____ Other _____

State conditions medication is given on as needed basis (PRN) _____

How soon can administration of PRN medication be repeated _____

Precautions/unfavorable reactions _____

PARENT/GUARDIAN CONSENT: (complete for ALL medications/procedures at school)

- I request and authorize that this medication be administered at school by school personnel.
- I will supply medication in its original, updated, properly labeled container (Request bottle from pharmacy)
- I will obtain a new physician's order and notify the school in writing for any changes.
- I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed
- I further understand that all medication should be delivered to parent, guardian or responsible adult.
- I understand that medication will be given by non-medically trained personnel.
- I agree to hold the St. Patrick School, its employees and agents who are acting within the scope of their duties harmless in any way and all claims arising from the administration of this medication at school.
- My signature indicates that I have fully read and understand the above information.
- ASTHMA INHALER AND EPI-PENS ONLY: This student is capable of self-administration and may carry inhaler or Epi-pen and self-administer at school. YES _____ NO _____

Parent Signature _____ Date ___/____/____

PHYSICIAN ORDER: (Complete for all Prescription Medication/Procedures)

The above medication/procedure is to be administered/performed during the school day in accordance with the above instructions and agreements. I agree to accept communication about student/medication/procedure and understand medication will be given by non-medically trained school personnel.

Contact me if the following symptoms occur

_____

Physician Signature _____ Date ___/____/____

Record for Medication Administered by School Personnel

Student _____ Grade _____ Med/Proc _____

Dosage_____ Start Date: ___/____/____ Stop Date ___/____/____ Time(s) to be given_____

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Initials = Administered A = Absent X = No School O = Out of Medicine N = No Show R = Refused