ADMINISTRATION OF PRESCRIPTION NON/PRESCRIPTION MEDICATION FORM

All medications, even over-the-counter medications such as eye drops, cough drops and aspirin, must be labeled with prescription dosages and directions for administration. Students **ARE NOT** permitted to have any type of medication in their possession on school grounds, school functions, or on a school bus.

Student's Name _____ DOB _____ Grade _____

TO BE COMPLETED BY LICENSED PHYSICIAN

I hereby certify that it is medically necessary for _____ to receive medication during school hours.
1. DIAGNOSIS_____ 2. NAME OF MEDICATION_____
3. DOSAGES AND TIME TO BE ADMINISTERED AT SCHOOL**:** _____
****PLEASE NOTE**: Medications are administered at school by school staff who may have no medical training.
4. DURATION OF MEDICATION ORDER: _____ 5. SIDE EFFECTS OF MEDICATION:_____

DATE _____ SIGNATURE OF PHYSICIAN _____ PRINT NAME OF PHYSICIAN _____

PHONE NUMBER OF PHYSICIAN _____ ADDRESS OF PHYSICIAN _____

TO BE COMPLETED AND SIGNED BY PARENT OR LEGAL GUARDIAN

I hereby certify that it is medically necessary for _____ to receive medication during school hours.
1. DIAGNOSIS_____ 2. NAME OF MEDICATION_____
3. DOSAGE AND TIME TO BE ADMINISTERED AT SCHOOL**:** _____
****PLEASE NOTE**: Medications are administered at school by school staff who may have no medical training.
4. DURATION OF MEDICATION ORDER: _____ 5. SIDE EFFECTS OF MEDICATION:_____

Student's Name _____ DOB _____ Grade _____

For and in consideration of allowing said child to attend school in spite of his or her specific health problem, I hereby release, relieve and discharge Teurlings Catholic and/or any of its agents or employees from any and all liability from any injury or damage to the health of said child arising out of, or resulting from the necessity of said child having to take medication during school hours. I realize that people without medical training may be giving medication to my child. I have read and agree to the school's regulations concerning giving medication to students.

Parent's Signature _____ Date _____ Phone Number _____

PLEASE NOTE: MEDICATION MUST BE PICKED UP BY A PARENT AT THE END OF THE SCHOOL YEAR OTHERWISE IT WILL BE DISCARDED.