Our Mother of Perpetual Help School

Authorization for PRESCRIPTION Medication

Name of Student _____ Grade _____

In accordance with Diocesan policy #4108 all prescription medication must be in the original properly labeled container. The container should be "child-proof" and labeled by a pharmacist or a physician. The original container is to be accompanied by this completed form.

Name of physician prescribing the medication: _____

Name of the medication: _____

Physician's Directions:

a. Amount to be given: _____

b. Time to be given: _____

c. Date(s) to be given: _____

d. Reason: _____

Curtailment of specific school activities (if any): _____

Other medications which the student is taking: _____

Parent/Guardian Signature _____

Date: _____

Authorization for NON-PRESCRIPTION Medication – Confidential

Name of student _____ Date of birth _____

School _____ Grade _____

Medication _____

Manufacture's recommended dosage _____

Time(s) of day medication is to be given _____

Common side effects _____

_____

Special instructions by parent/guardian _____

_____

Has the first dose of this medication been given? YES NO

**School personnel are prohibited from giving the first dose of any medication.

I understand that some nonprescription medications, which may include the above listed medication, might cause my child to suffer an adverse reaction or other serious medical condition. I hereby release, waive, discharge and covenant not to sue the Diocese, Parish, School or their employees, officials, agents or volunteers for any liability for damages, injury or death that may result from ill effects or adverse reactions to this medication.

I authorize this medication to be administered at the School by staff persons or volunteers who are not physicians, licensed registered nurses (RNs), or licensed practical nurses (LPNs). I understand, acknowledge and approve that the individuals administering the medication do not have any form of medical license and will not perform a medical assessment of my child prior to administering the authorized medication.

`Further, I acknowledge that the School bears no responsibility for ensuring the medication is administered and that the Diocese, Parish, School or their officials, employees, agents or volunteers may decline to administer the medication. If the School declines to administer the medication, the School will take reasonable steps to notify you that the medication will not be administered.

I HEREBY CERTIFY THAT I HAVE READ THIS DOCUMENT IN FULL AND THAT I HAVE THE LEGAL AUTHORITY TO CONSENT TO THE ADMINISTRATION OF THIS MEDICATION.

Date _____ Signature of parent/guardian _____

Printed Name _____

Date _____ Witness (school employee) _____

Printed name _____

NOTE:
Nonprescription medication may be given for a specific, time-limited minor illness or for intermittent medical conditions. **If the medication is needed for more than ten doses, a prescription may be necessary in order for the medication to continue to be given at school.** The medication must be provided in its original container with a legible label, and authorized for the dosage recommended for children on the package. Authorization for nonprescription medication administered at school is required by the School.

Date/ Time/initials	Date/ Time/initials	Date/ Time/initials	Date/ Time/initials	Date/ Time/initials
Date/ Time/initials	Date/ Time/initials	Date/ Time/initials	Date/ Time/initials	Date/ Time/initials

THIS RELEASE IS TO BE RETAINED IN STUDENT'S MEDICAL FILE.