Students Name_____ Homeroom_____

REQUEST FOR THE ADMINISTRATION OF MEDICINE OR TREATMENT

The Administration of medication is normally not a function of education, but if it does become necessary for a student to take medicine at school then the following guidelines must be followed:

1. Provide the building principal (or nurse) with the district medication form completed, signed and dated by the physician and the parent/guardian.
2. Deliver medication to the school office via the parent/guardian or other responsible person. *Keep medicine out of the reach of children.*
3. Medication must be in a container appropriately labeled by the pharmacist/physician with: the student's name, the name of the medicine, the dosage and time interval in which the medication is to be taken, the name of the prescribing physician, and the date. NOTE: Non-prescription drugs must be in the original containers properly labeled with the student's name and the dosage and directions for administration at school.
4. Obtain written authorization from the physician for "self-administration" of PRN ("as needed") drugs or treatments such as inhalers, bee sting kits, glucose monitoring...
5. Notify the school when the drug is to be discontinued or there is a change in the dosage or interval of medication administration.
6. Renew the medication administration request forms annually.

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Please Note: The school does not assume responsibility for medication which is not delivered to and kept in the school office or other secure designated area.

Student's Name_____ Grade/Teacher_____

Parent/Guardian's Name_____ Emergency Phone Number_____

PHYSICIAN'S REQUEST FOR ADMINISTERING MEDICATION AT SCHOOL

Must this medication be given during the school day to allow the child to attend school?_____

Disease or illness involved _____ Medicine or Treatment_____Dosage and directions for administration at school_____

_____

_____Discontinuation Date_____

Possible Side Effects_____

Can this PRN medication/treatment be "self-administered" in the nurse's absence?_____

Is it medically necessary for the student to carry their inhaler or Epipen on their person at all times?_____
Physician's Signature_____Telephone No. _____Date_____

PARENT'S REQUEST FOR ADMINISTERING MEDICATION AT SCHOOL

I hereby request and grant permission for Seton Catholic School and its school personnel to dispense medication or to administer prescribed treatments to my daughter/son,_____ according to _____ (physician's name) instructions above. I further release and waive any claims against the School, its employees and agents arising out of the administration of said medication or treatments and agree to hold harmless and indemnify the School, its employees and agents, either jointly or severally, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs, and expenses, including attorney's fees, resulting from or arising out of the administration of medication or treatments to my daughter/son by school personnel.

Parent/Guardian's Signature_____Date_____

(The back of this form may be used to provide additional information as necessary)