



Immaculate Conception Catholic School Medication Release Form/ Long Term Meds

Important Instructions for Parents/Guardians and Physicians:

1. Medications will be given at school only with this release form completed by you and your child's physician.
2. Many OTC medications can be given at school. Pain relievers for dental work should be given prior to returning to school. Doctor recommended OTC medications will be given as needed, with permissions.
3. All medication must be in its original container and clearly state the name of the medication, dose and instructions, student's name, name of provider/physician, date prescribed, and expiration date.
4. The first full day's dose (24 hours) must be given at home.
5. One of these forms must accompany each new medication or change in dosage which may occur.
6. The medication and Release form must be delivered to school staff/personnel by the parent/child. Thank you for your cooperation!

Health Care Provider Authorization

Name of Student: _____ DOB: _____ / _____ / _____
Medication Name: _____ Dose: _____
Route: _____ Time/Frequency: _____ Duration: _____
Reason for Administration: _____
Other instructions: _____
Health Care Provider's Name (print): _____ Phone #: _____
Health Care Provider's Signature: _____ Date: _____ / _____ / _____

Parent/Guardian Authorization

- I give permission to Immaculate Conception Catholic School staff/personnel to administer this medication, as prescribed by my child's health care provider above.
- I will notify the school immediately if my child's health status changes, or if this medication is discontinued.
- I give permission to School personnel to contact my child's health care provider, if needed, regarding this medication.
- I will not hold the School or its staff responsible for any undesired reaction which may occur from this medication.

I have read and understand the "Directions" and "Authorization" sections listed above. (circle one): YES NO
I authorize School staff/personnel to administer this medication, as directed by the health care provider above, to my child. (circle one): YES NO

Parent/Guardian Signature: _____ Date: _____ / _____ / _____

Parent/Guardian Name (print): _____ Phone # _____