SHORT TERM MEDS

MEDICATION ADMINISTRATION RELEASE FORM

Date:_____

To: Immaculate Conception Catholic School

I request that you administer the medication I have provided, to my child, during the school day in accordance with the policy printed below. You are authorized to delegate this authority to another person if so desired. I will not hold the nurse/school staff responsible for any undesired reaction which may occur from this medication.

I agree to pay for ambulance service if used to transport my child from school to the doctor or hospital should he/she have a reaction to the medication.

Parent's Signature:_____

Student's Name:_____ Grade:_____

Name of Medication: _____ Dosage:_____

Specify Time to be given:_____ or “As Needed”_____

Treatment of the following condition:_____

_____

In case of emergency call:_____Phone#_____

MEDICATION PROCEDURE

1. The medication must be in the original container with child's name, prescription name & dosage.
2. No medication is to be administered (3) times or more at school.
3. We request the consent form be signed before any medication is given at school.
4. Permission for long-term medication must be renewed at the beginning of each year.
5. First day's dose (24 hrs) of new medication must be administered at home.
6. Medication must be delivered to the school office or nurse by the parent.

HANDWRITTEN NOTES ARE NOT ACCEPTABLE.