

Medication Permission Form

DUE DATE: JULY 28, 2011

Student's Name: _____ DOB: _____
School: St. Catherine's Montessori Classroom: _____

All medications whether prescribed by a physician or authorized prescriber or over-the-counter must have signed orders from the parent/ guardian and the physician or authorized prescriber. Parent/ guardian must bring medication to school office. The prescription or over-the-counter medication must be brought in the original container. For prescription medication the label must match the physician's or authorized prescriber instructions order. The physician or authorized prescriber instructions for the over-the-counter medication instruction must be within the instructions for use of the over-the-counter medication.

To be completed by the Physician or Authorized Prescriber:

Reason for the medication: _____

Name and strength Medication: _____

Medication Form:

<input type="checkbox"/> Tablet/capsule	<input type="checkbox"/> Liquid	<input type="checkbox"/> Inhaler	<input type="checkbox"/> Injection	<input type="checkbox"/> Other _____
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Amount and Time/s: _____

For PRN state the frequency, the time between dosages of medication, and maximum number of doses in a school day:

Start date for medication: _____ End date for the medication: _____

(All orders will be valid for the current school year.)

Additional information, instructions, restrictions and/or important side effects: _____

Physician or Authorized Prescriber Signature _____ Date _____

Physician's or Authorized Prescriber name (print):

Name _____

Phone Number _____ Fax number _____

To be completed by the Parent/ Guardian:

I instruct the school principal or the principal authorized personnel to give the medication as instructed above.

Do you want to be called before or after (circle) a PRN medication is given? Yes _____ No _____

Additional information/instructions or restrictions _____

Consent:

I hereby request that the medication specified above be given to the above named student. I understand that the school personnel who give the medication may not be a medically trained person.

I realize that the school does not have to agree to allow medication to be given to a student by school personnel. I understand that the school's agreeing to allow the medication to be given is for my benefit and the student's benefit. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the Archdiocese of Galveston – Houston, its servants, agents, and employees including, but not limited to the parish, the school, the principal, and the individuals giving the medication of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Archdiocese of Galveston – Houston, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to give the medication.

Parent/ Guardian Signature _____ Date _____

Printed name _____ Relation to the child _____

(Special forms are required for severe allergies and administration of Epipens, administration of diabetic medication, and self-administration and carrying of asthma medication.)