PHYSICIAN AND PARENT REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

20_____ / 20_____ School Year

Authorization must be renewed every school year

TO BE COMPLETED BY PARENT / GUARDIAN: I hereby request, authorize and give permission to the principle or his / her designee, (e.g., school nurse or responsible person) to administer the following medication to my child.

Student's name _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

MEDICATION

DRUG NAME	DOSAGE	TIME OF DAY	MED. FORM (e.g. liquid or tablet)

Beginning and expiration date of this request_____

Signature of parent / guardian _____ Date_____

It is not possible for this medication to be taken at home by my son/daughter, and it must be administered during the school day.

In consideration of my child being administered the above specified medication at my request, on behalf of my child, my spouse, and myself. I hereby assume all risks in connection therewith, and I further release the Diocese of Cleveland, the Bishop of the Roman Catholic Diocese of Cleveland, _____ School, _____Parish, employees and volunteers from all claims, judgments, liability for any injury or damage due to the designated administration of said medication to my son / daughter.

TO BE COMPLETED BY THE PHYSICIAN: It is not possible for the above specified medication to be taken at home under the supervision of a parent and it is, therefore, necessary that the specified medication be administered during school hours. The medication provided shall be in the original container obtained by the parent / guardian from the pharmacist. This medication can be safely administered by non-medical personnel.

Student's name_____ Date of Birth _____

DRUG NAME	DOSAGE/ROUTE	FREQUENCY & TIME OF DAY	SPECIAL INSTRUCTIONS

Reactions / Side effects_____

Beginning and expiration date of this request_____

Signature of physician _____ Date_____

Physician's address_____ Phone_____