

Annunciation Catholic School
ADMINISTRATION OF MEDICATION FORM

School policy and state law require consent of the parent/legal guardian and written statement from the licensed prescriber before school personnel can give any medication to a student. (The only exception is the medication listed on the Over The Counter Medication Form) Please return this completed form to the school office.

Name of Student \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_ Homeroom \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Allergies \_\_\_\_\_

To be completed by LICENSED PRESCRIBER

Name of Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Route \_\_\_\_\_

Time/Frequency to administer \_\_\_\_\_

Specific instructions for administration \_\_\_\_\_

Condition for which medication is administered \_\_\_\_\_

Possible side effects to be noted/reported \_\_\_\_\_

Special conditions for storage of medication \_\_\_\_\_

Effective Date of this request \_\_\_\_\_ Expiration Date of the request \_\_\_\_\_

For ASTHMA INHALERS, EPI-PENS, INSULIN PUMPS - In my opinion, this student shows the ability to administer and be responsible for carrying and self-administering the above medication. YES \_\_\_\_\_ NO \_\_\_\_\_

Please provide Emergency Action Plan with procedures to follow if the emergency medication does not alleviate student's emergency. Instructions to follow in the event medication does not produce expected \_\_\_\_\_

Licensed Prescriber Signature \_\_\_\_\_

Print Name \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
Phone Number

To be completed by PARENT/GUARDIAN

I give permission for the principal or his/her designee to administer the medication as prescribed above to my child, and further agree to the following:

- 1. Submit to school personnel a revised statement, signed by the licensed prescriber of the above, when any change in the original statement occurs.
2. Submit to school personnel a written statement when medication has been discontinued.
3. Grant permission for the school nurse to confer with the above licensed prescriber regarding my child's health and treatment issues as they pertain to the above medication/diagnosis and his/her educational and behavioral management needs.
4. Cooperate with school personnel in assisting my child with medication administration instructions.
5. All medications must come to school in the original container from the pharmacist, clearly marked with student's name, medication name, dose directions, doctor, and prescription number.

FOR INHALERS, EPI-PENS AND INSULIN PUMPS: It is my opinion that my child understands the use of this medication, demonstrates proper administration and has shown responsible behavior when it comes to carrying this medication. YES \_\_\_\_\_ NO \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
Parent/Guardian Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
Daytime Phone Number