Diocese of Monterey

Physician Order and Parental Authorization to Administer Medication
(Transitional Kindergarten through High School)

In order for a student to receive medication at school or during school-related activities, the following criteria must be met:

1. A new form must be completed **each** school year for **each** medication. A new form must also be completed whenever there is a change in the medication: name, form (tablet, capsule, liquid), dose (amount), or time given. If there are no changes, each form is good from August 1 of one year until July 31 of the following year.
2. A form is required for **any** medication: prescription, over-the-counter medicine or herbal supplement.
3. **For prescription medications both parent/guardian and physician must complete and sign this form**.
4. All medication must be in the original container or original package, and prescription medication must have the current prescription label.
5. The original form **must** be on file at the school. Medication and completed forms must be brought to the school by the parent.

Parent Authorization **School Year**: ______________

Student: ________________________________ Date of Birth: ____________ Grade: __________
(Please Print)
Parent/Guardian: ___________________________ Phone: ____________________________
(Please Print)
Address: _________________________________ Cist Zip: ____________________________

School: ____

If Parent/Guardian is Unavailable, Emergency Contact:

Name: ______________________________ Relationship: __________ Phone: ___________

* *

My child will need to take___________________ at school. It is to be given at ______________
(Print Medication Name) (Time/s)
With the following special instructions: ____

I, the undersigned, who is the parent/guardian of the above-named student, requests that medication be administered to said child by a designated member of the school staff, in accordance with instructions outlined on the reverse side and authorized by our physician. I understand that there is no nurse on duty and non-medical staff will administer the medication. I understand that I have the right to come to the School and administer the medication myself.

I give my permission for the principal or designee, to communicate with my child's physician regarding the physicians' written statement for medication administration.

I understand the major responsibility for a child taking medication rests with the child and me as his/her parent/guardian, and that I am required personally to bring the medication to the School.

I also agree that the School and the Diocese of Monterey Parish & School Operating Corporation and its employees shall not be held liable for any loss, damage, injury or liability of any kind to any person caused or arising from acts, omissions or negligence of the School or the Diocese of Monterey Parish & School Operating Corporation related to the administration of medication or by the student's self-administration of medication.

Parent/Guardian Signature: ____________________________________ **Date**: _______________

Diocese of Monterey

Student: _____ **Date of Birth**: _____

Physician Order for Prescription Medication (Print):

1. Name of Medication: _____
2. Reason for Medication: _____
3. Dosage: _____
4. Time/s: _____
5. Method: Oral __ Inhalation __ Injection __ Topical __ Other/Explain: _____
6. Possible Side Effects:
7. Special Storage Requirements:
8. Special Instructions/Precautions:
9. Will student need to personally carry this medication? _____Yes _____ No
10. Will the student be "self" administering this medication? _____Yes _____ No

The listed medication/s is necessary for:

_____ A potentially life-threatening condition
_____ Appropriate pupil interaction in school setting
_____ To treat a current illness
_____ Student comfort

Physician's Name (Print) _____

Physician's Signature: _____ Date: _____

Address: _____ Phone: _____

CiStZip: _____ Fax: _____

PARENT REQUEST FOR MEDICATION SELF-ADMINISTERED BY STUDENT AND REQUIRING SPECIAL STORAGE

Student's Name: _____ Birth Date: _____Grade: ____ School: _____

I, the undersigned, who is the parent/guardian of the above-named student, request and authorize the staff of _____ (School) to store my child's medication at the School site. As indicated in the physician's statement above, my child will self-administer his/her own medication when required, and I am not requesting School personnel to assist in the administration of my child's medication. However, I understand that all medication must be stored in the School office unless a physician orders that the student must personally carry the medication. I also understand that my child must self-administer the medications in the School office

My child will need to self-administer his/her medication at School because he/she suffers from the following condition:
_____

My child will need to take his/her medication (number of times per day) with the following special instructions:
_____

I request that my student's medication be stored in the following manner: _____

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

Address: _____ **CiStZip**: _____

Home Phone: _____**Work Phone**: _____

updated 7/13/2015