

ST. PAUL'S PREPARATORY ACADEMY

REQUEST FOR ADMINISTRATION OF MEDICATION

Prescription Rx

If medications can be given at home or after school hours, please do so. However, if medication administration is absolutely necessary to be given during school hours, this form must be completed.

Permission is hereby granted to the local school principal or his/her designee to supervise my child in taking the following prescribed medication.

I agree not to seek to sue St. Paul's Preparatory Academy, its employees and officials for side effects of medication or illness from taking medication as written on the container of the medicine since St. Paul's Preparatory Academy, its employees and officials have no control over the prescription of the medication and the medical instructions for the use of the medication. Should any suit be brought for merely supervising the taking of the medication following the instructions accurately on the container in which the medication is found, I agree to indemnify and hold harmless St. Paul's Preparatory Academy, its employees and officials for this litigation if the administering of the medication is found to have been in accordance with the instructions on the container.

I give the above-mentioned personnel permission to contact my child's health care provider and/or pharmacy to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.

I understand that:

1. All medications, herbals, and supplement must be approved by the U.S. Food and Drug Administration and appear in the U.S. Pharmacopeia
2. **Medications must be in the original container.**
3. Parent/Guardian must provide specific instructions (including drugs and related equipment) to the principal or his/her designee.
4. It will be the responsibility of the parent/guardian to inform the school of any changes in pertinent data. New medications will not be given unless a new form is completed.
5. All medication will be taken directly to the office by the parent or guardian. Students **may not** have medication in their possession except with a physician's request or a physician's order on file in the school's office.
6. A daily record shall be kept on each medication administered. This record will include student's name, date, medication administered, time, and signature of school personnel who supervised.
7. **MEDICATIONS MUST BE PICKED UP BY PARENT/GUARDIAN.** Any medication not picked up from the school by the end of the last day of the year will be considered abandoned. Abandoned medication will be properly discarded in accordance with local, state, and federal laws/rules by the school nurse and administrator.

NAME OF STUDENT _____

TEACHER _____ GRADE _____

MEDICATION _____ DOSAGE _____

TIME _____

ALLERGIES _____

PHYSICIAN'S NAME _____ PHYSICIAN'S PHONE _____

STATEMENT OF PARENT OR GUARDIAN

I hereby give my permission for my child to receive this medication at school.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

HOME PHONE _____ WORK _____ CELL _____

ST. PAUL'S PREPARATORY ACADEMY

REQUEST FOR ADMINISTRATION OF MEDICATION

Over-The-Counter

If medications can be given at home or after school hours, please do so. However, if medication administration is absolutely necessary to be given during school hours, this form must be completed.

Permission is hereby granted to the local school principal or his/her designee to supervise my child in taking the following prescribed medication.

I agree not to seek to sue St. Paul's Preparatory Academy, its employees and officials for side effects of medication or illness from taking medication as written on the container of the medicine since St. Paul's Preparatory Academy, its employees and officials have no control over the prescription of the medication and the medical instructions for the use of the medication. Should any suit be brought for merely supervising the taking of the medication following the instructions accurately on the container in which the medication is found, I agree to indemnify and hold harmless St. Paul's Preparatory Academy, its employees and officials for this litigation if the administering of the medication is found to have been in accordance with the instructions on the container.

I give the above-mentioned personnel permission to contact my child's health care provider and/or pharmacy to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.

I understand that:

1. All medications, herbals, and supplement must be approved by the U.S. Food and Drug Administration and appear in the U.S. Pharmacopeia
2. **Medications must be in the original container.**
3. Parent/Guardian must provide specific instructions (including drugs and related equipment) to the principal or his/her designee.
4. It will be the responsibility of the parent/guardian to inform the school of any changes in pertinent data. New medications will not be given unless a new form is completed.
5. All medication will be taken directly to the office by the parent or guardian. Students **may not** have medication in their possession except with a physician's request or a physician's order on file in the school's office.
6. A daily record shall be kept on each medication administered. This record will include student's name, date, medication administered, time, and signature of school personnel who supervised.
7. **MEDICATIONS MUST BE PICKED UP BY PARENT/GUARDIAN.** Any medication not picked up from the school by the end of the last day of the year will be considered abandoned. Abandoned medication will be properly discarded in accordance with local, state, and federal laws/rules by the school nurse and administrator.

NAME OF STUDENT _____

TEACHER _____ GRADE _____

MEDICATION _____ DOSAGE _____

TIME _____

ALLERGIES _____

PHYSICIAN'S NAME _____ PHYSICIAN'S PHONE _____

STATEMENT OF PARENT OR GUARDIAN

I hereby give my permission for my child to receive this medication at school.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

HOME PHONE _____ WORK _____ CELL _____