Holy Name of Jesus School

PARENTAL REQUEST AND PHYSICIAN'S ORDER FOR MEDICATION

(For students who require medication during school hours)

This form is to be completed to implement the storage, dispensing, student supervision or administration of a medication. Medication will be counted when received, parent should count medication before sending to school.

Pharmacy containers must be clearly labeled with the child's name, name of physician, date of the prescription, name and telephone number of pharmacy, name of medication, dosage, and frequency of administration.

The school nurse or principal's designee will store the medication, with the prescription label, in a secure place for the period indicated on the physician's order. Medications not picked up at the end of the school year will be destroyed.

I, as the parent or legal guardian of_____ in homeroom _____, hereby
(Please Print Child's Name)

request and authorize the ***Holy Name of Jesus School*** and its nurses and/or designated employees to administer or assist the student in self-administration of medication to _____. I understand and acknowledge: that school personnel other than the school nurse may be involved in the administration of medication to my child; that school personnel as appropriate may be advised of the administration of medication to my child. If anyone other than my spouse or me delivers the medication to the school, the medication will be delivered in a sealed envelope signed by me. This agreement shall be effective for the school year or until revoked by me in writing. I agree and understand that I am responsible for delivering required medication to the school in a suitable labeled container and that no medication will be administered that is not properly delivered and labeled. I hereby authorized any treating health care provider to discuss my child's medication, need for medication and related information with representatives of Holy Name of Jesus School.

_____	_____	_____	_____
Parent/Guardian Signature	*Home Phone*	*Work Phone*	*Date*

TO BE COMPLETED BY PHYSICIAN:

NOTICE: The school urges physicians to time medication whenever possible so that it can be taken at home under the supervision of the parents. The school staff will supervise pupils taking medication or administer the medication if failure to take such medication during school hours would jeopardize the health of the student and/or the student would not be able to attend school without it.

It is necessary that _____ receive the following medication at the times stated below.
(Child's Name)

Please store and administer the following:

_____	_____	_____
Name of Medication	*Dosage*	*Times to be Taken*

Route of Administration: _____

Self-Administered: YES _____ NO _____

Other Specific Directions: _____

Purpose of Medication and/or Diagnosis: _____

Side Effects to watch for are _____

Duration of Order is _____

_____	_____	_____	_____
Physician's Name (please print)	*Physician's Signature*	*Telephone*	*Date*