Archdiocese of Baltimore
Monsignor Slade Catholic School
PARENT'S REQUEST TO ADMINISTER MEDICATION AT SCHOOL

To be completed by parent/guardian:

Name of Student_____ Date of Birth_____Grade___School Yr___
(Last, First, MI)

In order for my child to receive medications in school, I agree to the following:

- ✓ All prescription and non-prescription medications will have a physician's signed order fully completed for each school year.
- ✓ All prescription medications will be in a container labeled by the pharmacist or physician with:
  Name of child *Name of the Medication* *Dosage, route and time of administration*
  Name of physician *Prescription date and expiration date* *Conditions for proper storage*
- ✓ All non-prescription medication will be in the original sealed container with the label intact. Student's name will be put on the container in a position that does not obscure the label.
- ✓ An adult will bring the medication to school.
- ✓ The physician will be called if a question arises about my child's medication.
- ✓ The first dose of this medication (except for Epi-Pen and Glucagon) has been given without problems.

> **The child's physician must complete the Physician's Signed Order below. <u>All medications require physician signature</u>.**

PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL

Name of Student: _____ DOB: _____/_____/_____
(Last First M.I.)

Diagnosis: _____

Name of Medication: _____

Dosage: _____(mg, ml, ml/tsp, # of puffs)

Route: _____ Time of administration at school _____

If PRN for what symptoms? _____ How Often? _____

Please list any specific precautions personnel should be aware of or any unusual effects that might be observed
_____

Service should begin _____ (date) and terminate _____ (date)

FOR INHALER, EPI-PEN, AND INSULIN ONLY.
___It has been determined that this student is able to self administer and carry inhalant medication or Epi-Pen, and has been trained in its use, including knowing when the medication is to be used.
___ It has been determined that this student is able to self-administer insulin.
___ This student should not self administer inhalant medication or Epi-Pen..

> **Physician's signature: _____ Physician's name (printed): _____**

Address: _____ Phone number: _____
_____

Having read the above conditions, I request Monsignor Slade Health Services Personnel to administer the medications as prescribed by the physician above to my child. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. We assure that the first dose of this medication has been given without problems (excluding Epi-Pen and Glucagon).

Signature of parent/guardian_____Date:_____
Relationship to student_____
Phone Number(H)_____(W)_____(C)_____

- Order Reviewed by delegating nurse_____Date_____